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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 1

June 1991

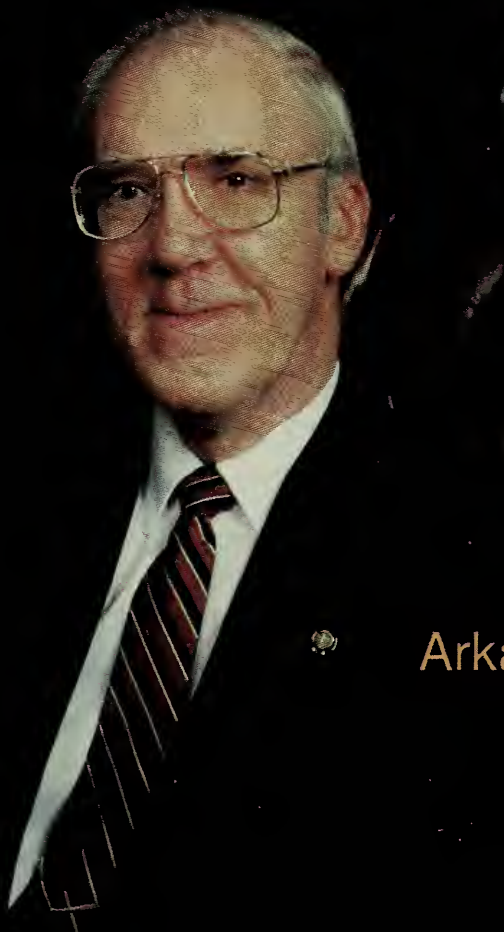
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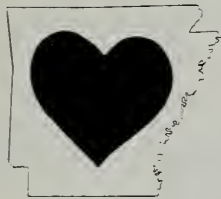
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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 1

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## CONTENTS

### FEATURES

- |    |   |
|----|---|
| 7  | Good Medicine 1991: Politics and Art<br><i>Inaugural Address</i><br>George W. Warren, M.D.  |
| 12 | Presentations to the House of Delegates<br>12 Governor Bill Clinton<br>18 Congressman William Dannemeyer  |
| 27 | Proceedings of the 115th Annual Session<br>27 First Session<br>28 Late Resolutions<br>29 Final Session<br>30 Reference Committee 1<br>32 Reference Committee 2<br>34 Report of the Council<br>36 1991-92 Officers |
| 40 | Presentations to the House of Delegates<br>40 William N. Jones, M.D.<br>44 John Clowe, M.D.<br>48 Mrs. David Williams<br>49 Mrs. Charles Rodgers<br>50 Mrs. Joe Ed Smith  |
| 51 | Auxiliary Convention Report   |

### DEPARTMENTS

- |    |                                |
|----|--------------------------------|
| 58 | AMS Newsmakers                 |
| 59 | New Members                    |
| 60 | AIDS in Arkansas Statistics    |
| 63 | Radiological Case of the Month |
| 66 | Medicine in the News           |
| 68 | ECG of the Month               |
| 70 | Things to Come                 |
| 71 | Keeping Up                     |

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# Good Medicine 1991: Politics and Art



## George W. Warren, M.D. Inaugural Address

Dr. Jones, officers, delegates, and guests:

I deeply appreciate the honor of serving for the next year as your president. In the 115 year history of the Arkansas Medical Society, I am but the second physician from Union County to receive this honor.

Jeanne and I are very please to have several guests who have come to help us celebrate this occasion. It is with great pleasure that I introduce first our sons and their wives.

From Houston, Texas, our first son, Bryce and his wife Paula. Our baseball playing grandsons, Blake and Zachary were unable to attend.

Our second son, Emory and his wife Sharon, join us from Little Rock. Emory, following his father's example, is a physician. I recently learned how the Doctors Warren are differentiated. The receptionist of a physician to whom we both refer patients, on hearing my name said, "Oh, are you the old or the young Dr. Warren?"

Our youngest son, Les and his wife Pam, currently live in Little Rock but are soon to become residents of Conway. Our youngest grandson, Colby, remained at home.

Minus 3 important members, this is our family.

Dr. Joseph Czarsty and his wife Bobbie have come all the way from Oakville, Connecticut. Joe is a past president of the Connecticut Medical Society and the Connecticut

Academy of Family Physicians. Bobbie is a past officer of the American Medical Association Auxiliary. Joe and I served together on the American Academy of Family Physicians Board of Directors, of which body Joe served as chairman. It is rumored that Bobbie and Jeanne are certified black belt members of "Shoppers Anonymous."

Joining us from Bethany, Oklahoma, is Dr. Kenneth Whittington and his wife Alice. Dr. Whittington, with whom I served three years on the American Academy of Family Physician's Board of Directors, is the Academy's immediate past president. Alice, in addition to all of her other duties, serves as Ken's travel agent.

Joining us from Oklahoma City, Oklahoma, is Dr. Perry Lambird and his wife Mona. Dr. Lambird is president of the Oklahoma State Medical Association and a delegate to the AMA.

Joining us from the Magnolia State, from Laurel Mississippi, Dr. James Waites and his wife Jo. Dr. Waites is president-elect of the Mississippi State Medical Association and a delegate to the AMA. Dr. Waites, I was recently given a book, "The Diary of a Country Doctor" written by Dr. W.W. Walley of Waynesboro, in which you wrote the foreword. One of Dr. Walley's experiences, with which many of us can identify, concerned his usual habit of getting



home late for his evening meal. On one such occasion, his five year-old daughter greeted him at the door with the announcement that she wanted him to get a job at the local veneer factory. Somewhat taken back by her remarks he asked her why. Her answer is the answer many children, including mine, could have given, "so you could be like other daddies and get home at five o'clock."

In making my last introduction, I want to borrow one more quote from Dr. Walley. He states, "It takes a special kind of woman to be a doctor's wife, she has to be three people in one. A wife, a mother, and in altogether too many instances, a surrogate father. Jeanne, my wife of 38+ years, qualifies in all respects. Our family and our friends have made ours a full happy life.

I have entitled my remarks tonight "Good Medicine 1991: Politics and Art." To develop that theme I will first, acknowledge the legacy to which an incoming president of the Arkansas Medical Society falls heir; second, identify two of today's major challenges; and third, enlist you in fulfilling two priority actions.



## The Legacy

As I approached my year as president, I became increasingly aware and appreciative of what the Arkansas Medical Society has done for medicine, for the people of Arkansas, for our patients, and for physicians.

I have enjoyed the privilege of serving my learning year under an outstanding, and I will add "outspoken" leader, Dr. Bill Jones. When the leadership of the AMA listens and responds as it did last year to Bill's concerns, then you know he is not only outspoken but heard. Bill, when I say your act will be a hard one to follow that's no cliché. I rejoice that you will be available to me as a resource and as a member of the Executive Committee. I welcome your continued active involvement.

I cannot overstate my gratification in serving on the Executive Committee with Bill and with Drs. James Weber, Larry Lawson and Charles Rodgers. These physicians have

intimate knowledge of the intricacies of medical politics. Their knowledge has enabled our Society to stay abreast, and yes, ahead of many problems.

Fulfilling our Executive Committee's responsibilities has not always been easy. Nonetheless, we have faced up to our duties and at times withstood underserved criticisms for our actions. We have, for example, in the area of Workmen's Compensation been pro-active. We now have an excellent working relationship with the Workmen's Compensation Commission. David Wroten, thanks for your help in making this good relationship possible.

The Arkansas Medical Society, working with our representatives in Washington, was in the forefront of the battle on the Clinical Lab Improvement of 1988. This proposed law would have been disastrous for small rural hospitals and primary care physicians' offices. It had, and has, more potential to damage access to care than any yet proposed Federal Act. We succeeded in delaying action, and despite continued efforts to assure needed changes, find ourselves in position to have to fight the battle again.

Obviously, I consider part of the Society's legacy the individuals with whom I share leadership. Having served with Dr. Larry Lawson on the Council and Executive Committee, I now enjoy my new relationship with him as president-elect. We work well together. He serves the Society well.

We officers, past and present, know how fortunate we are in our headquarter's staff. For all of us who benefit, I express profound appreciation for all they do, under the capable leadership of Mr. Ken LaMastus. To be a good leader one must be surrounded by good help. David Wroten, Peggy Cryer, Lynn Zeno, and all staff members, I thank you. (But not nearly so fervently as I will 12 months from now.)

For an incoming president that's a rich legacy, don't you agree? A vibrant, dynamic, results-oriented organization, capably led and professionally staffed, on the move. I consider it a legacy that simultaneously inspires and challenges.

## The Major Challenges

I zero in on two. Though at times it has been difficult, I have always been an optimist. A recently noted definition of a pessimist, however, gives me cause for some concern. A pessimist, it seems, is an optimist with experience. Certainly our experiences of the past 25 years, especially since the onset of Medicare, have given many of us a new insight into pessimism.

Now to the first of the two challenges: political impotence. As a profession we need to recognize one of our major deficiencies, a lack of physician participation in political affairs.

For my many years as an active member of the Arkansas Medical Society, the American Academy of Family Physicians in Arkansas and nationally, and the American Medical Association, I have felt that medicine has always been on the defensive. We were reactive rather than pro-active. In



altogether too many instances our efforts have been divided and our results failure, or second best.

Recall how professional liability problems mushroomed. Our cries for help in Tort Reform fell, in most instances, on deaf ears. Liability insurance rates reached such proportions that many physicians had to curtail or forego certain disciplines of practice. Thus begun the difficulties associated with access to care. With the cost of medicine escalating so rapidly, medical insurance rates zoomed to such heights that the number of un- or under-insured people reached a wildly unacceptable figure of 37 million.

Our headquarters staff does an outstanding job in political affairs, especially Lynn Zeno, our full-time staff person charged with governmental affairs. There have been a few successful ventures by physician groups, most notably in Boone and Jefferson counties with Bob and Lloyd Langston leading the way. As successful as these ventures have been, they only scratch the surface.

Nikki Lawson ran for the House of Representatives from her district. Although she did not win, she showed courage. I won't ask Nikki to tell us how many or how few physicians statewide helped her financially. I can, however, turn to another physician candidate, Dr. Hampton Roy, who has twice sought statewide elective office. While Dr. Roy has not yet been successful in a statewide election, he was last year elected to public office in Little Rock. In an article published in the February 1991 issue of *The Journal of the Arkansas Medical Society*, Dr. Roy listed many ways physicians and spouses can help in any election campaign, finances being one. From Dr. Roy's figures it is not difficult to see that as a group we do not do our part.

Recent figures reveal fewer than 20% statewide participate with individual contributions or support with help in a campaign.

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## “Medicine needs to regain its rightful #1 position.”

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As a group we have not carried our part of the load. Too few are expected to do too much for too many.

Our second challenge concerns physicians' loss of public trust and esteem. We have fallen from #1, not to #2, but several rungs down the public opinion ladder. The view from the top should be the #1 priority for all of medicine. Medicine needs to regain its rightful #1 position.

Thirty years ago, physicians held an esteemed position in Society. The #1 individual in people's minds as their friend and their advocate was the doctor. This concept held fast for many years. The cost of medicine began to escalate

rapidly. Physicians, in many instances, became enamored of living the good life. Money, and what it could provide, became for too many a desired standard. Our esteemed position of trust eroded.

Our medical history is filled with physicians who placed their patients' needs above their own. Today, we have a change in attitude by too many physicians whose attitude is to care for others after they care for themselves.

In my brief acceptance remarks last year, I expressed concern about what I feel is today's "Achilles' Heel" of



American medicine. In a national poll in June 1990, 90% of the respondents expressed a desire to have a personal physician.

During that same week on Good Morning America, Charles Gibson interviewed several people concerning their relationships with their doctors. Their remarks conveyed a singular theme, "My doctor is a good doctor, but he does not seem to be interested in me." Not one person interviewed expressed a favorable opinion of his or her patient/doctor relationship. I personally perceived that those patients had simply never been exposed to the real "art of medicine."

### The Two Priority Actions

You will not be surprised that they correspond with the challenges just documented.

Please look to the "Warren-Lawson Administration" to beat the drums for the Arkansas Medical Society to come alive politically.

Every member must be registered to vote and an active voter. Each must encourage their spouse and other voting age members of the family.

More members and spouses must seek office - elective or appointive. We need more Nikki Lawson's and Hampton Roy's. We need more Bob and Lloyd Langston's doing what they do politically in Boone and Jefferson counties.

I noted earlier that our headquarters staff, and particularly Lynn Zeno, do an outstanding job in the political arena.



When we see the regrettably small minority of our members who are politically active, it becomes difficult to understand how so much is actually accomplished. In the past four years, however, as Willie Oates would say, "We have come a long way."

Thanks, Willie. You took the words right out of my mouth.

I want to thank Ken LaMastus for his foresight and persistence in getting Lynn Zeno to join our staff as director of Governmental Affairs. Thank you, Lynn Zeno, for your outstanding work these past four years. The 1991 Legislative Session was for the Arkansas Medical Society the best we have had in many years. Therefore, in addition to Lynn Zeno I want to pay special tribute to an individual whose many long hours of hard work contributed significantly to our legislative success, our legal counsel, Mike Mitchell. Yes, we have come a long way, but we still have a long way to go.

If physicians were as disciplined in making contributions as chiropractors, optometrists, and lawyers, it is awesome to consider how successful we could be. We need a larger percentage of our membership to be contributors to MED-PAC. More importantly, we need more members of



the President's Club.

Our second priority action. How can we again be #1 with our patients? I do have some recommendations. In a novel I read recently, I came across an old Buddhist saying, "Good health is the greatest blessing, and contentment is the best possession." We have the scientific ability to provide good health. Contentment will be achieved only by our practice of the "art of medicine."

As most doctors do, I have a prescription, an old fashioned compounded prescription, that will help to define the "art of medicine."

First, we must have the RIGHT ATTITUDE. We must understand that nothing great will be achieved without great men and women, and men and women are great only if they determine to be. I know from personal experience that a wonderful doctor/patient relationship continues to be available. It is there if we will assure it.

The next ingredient in this prescription for the "art of medicine" has to be HARD WORK. The will to succeed will find a way. There have been times in my practice when I felt that my patient encounter was concluded but the patient was not through. We must convince patients that for that period of time with them, their health is our primary concern. This will go a long way toward providing contentment.

To accomplish this at times seemingly impossible task, we must next add in CARE FOR OTHERS. A caring attitude

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"...we must enter the political arena, persist and prevail..."

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must be at the heart of our relationship with our patients. We must live our motto, "I care about you." Treating an illness with scientific acumen is the expectation. If in the process of using the science of medicine, we demonstrate that we care deeply that the treatment succeeds, we are true practitioners of the "art of medicine."

In the end, it all comes down to the fourth substance, the catalyst if you will, FAITH IN GOD. Patient and physician alike repose their confidence in the Creator's healing power.

A credo for practicing the "art of medicine" calls for "a welcoming smile, a sympathetic ear, an understanding empathy and a kind word in conversation." These four manifest God's love.

Eager then to move ahead on these priority actions, I offer these thoughts on "Good Medicine 1991: Politics and Art." In this my year as president of the Arkansas Medical Society, I will remember first the rich inheritances with which I am being entrusted.

Secondly, challenges abound. I specified two: political ineffectiveness and loss of professional stature.


Thirdly, we must initiate priority actions. I named two, corresponding to our challenges: we must enter the political arena, persist and prevail; and we, as physicians, must regain our rightful #1 position in public esteem.

Lord Chesterfield once said, "You must know the true value of time, snatch, seize and enjoy every moment of it. No idleness, no laziness, no procrastination, never put off until tomorrow what you can do today."

With the help of all of our members, the ever willing and able staff, and our trusted and beloved Auxiliary, I will convey to our patients that physicians do care. We are our patients' advocates and we must accept this at times unwanted responsibility. Accepting this responsibility, I need the help of all who are concerned with the delivery of patient care.

I will depend on your help. Together we can and must succeed.





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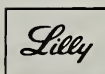
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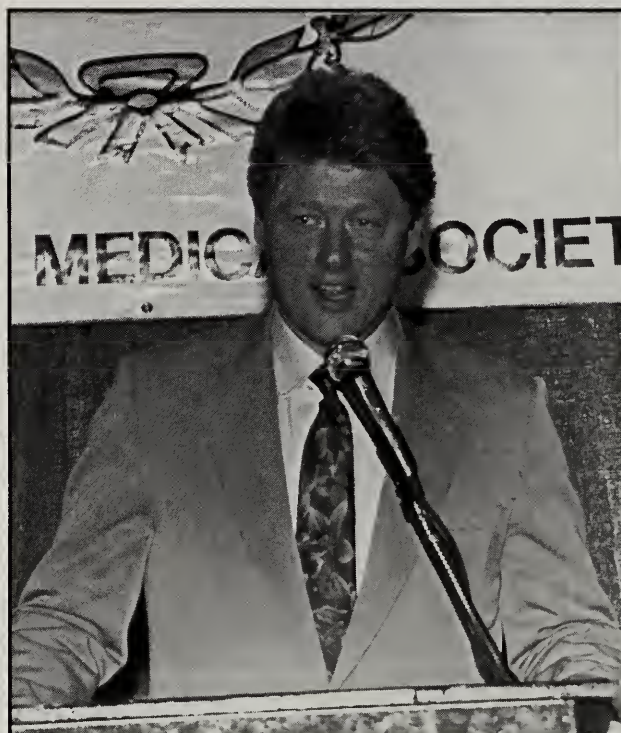
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# Address by the Honorable Bill Clinton Governor State of Arkansas



I want to thank you for a number of things. First of all, for the opportunity to come and share a few thoughts with you today.

Secondly, I would like to thank all of you who were involved, and a number of you were because I can tell by looking through this audience, in the eight or nine meetings I had last year with health care providers throughout the state after I was asked by my colleagues in the Governors' Association to be the co-chairman of the Health Care Task Force to try to see what the governors could do to deal with some of the health issues being debated around the country. I have to say that the meetings that I held with many of you had a big influence on me and had something to do with the shaping of the health care agenda which was presented to this legislature and I hope will eventually find its way into national health care policy. And to all of you, I appreciate that.

The next thing I would like to do is to tell you how much I did truly appreciate Ken, Lynn, and all of your medical representatives in the last session and how much I appreciate your support for the increase in the Medicaid program and the provider fees which will fuel that.

I'm very upbeat about the prospects of improved health care in Arkansas. I want to talk a little bit about specifics. As all of you know, I'm sure, by now, we are going to use the increase in Medicaid fees, not only to expand the services,

but also to increase reimbursement. We are trying to do some other things to facilitate the program and make it work better to make it more user friendly to you. I hope the program will be sufficiently more attractive to a lot of people who will have more Medicaid providers among our physicians when the new program kicks in on January 1.

It's been an interesting year or two for me in state government not only because of the campaign, but because of the significant budgetary problems that are gripping state governments throughout the country. Trying to figure out how to deal with them has become numbing. In my old age, now that I have all this gray hair, I don't call people in the middle of the night and get mad at them like I used to.

I have learned that Ben Franklin once said that our critics are our best friends for they show us our faults. Well, I have tried to adopt that philosophy. I have also learned the hard way that our words don't always mean what it appears they are going to mean when you first hear them.

I'm going to tell one story even though I don't tell many jokes because I thought it was pretty funny. It's my conjecture that most of you here are married and I will tell this story because I think you will enjoy it more. There was a man and a woman on a train taking a long trip across the country and they did not know each other, but at the end of the day they found themselves together in the same sleeping car. The lady



was on the top and the man was on the bottom. About 11 o'clock at night she rustled the curtain and said, "Sir, excuse me, I hate to wake you up but I am about to freeze to death. Would you mind going and getting me a blanket?" And he said, "Lady, before I do that, let me ask you a question. Are you married?" She said, "No, I'm not." He said, "Well, I'm not either. If you're all that cold, why don't we just play-like we're married?" She said, "You're the most forward man I have ever met in my life. But you know, this is a once-in-a-lifetime trip for me and no one will ever know. O.K., let's do it." He said, "Fine, go get your own blanket."

So you see, words aren't always what they seem anyway. You learn to blow them off as you go along.

Lynn has already summarized what was done, but let me try to graphically describe the importance, from my perspective, of what we all did together with the Medicaid program. In the last ten years the fastest growing parts of any state budget have been Medicaid and prisons. Also, during the last ten years states have been required by action of the President and Congress, to assume greater and greater burdens for education, the environment, and economic development. Those things which are critical to our future.

As the federal government has sort of receded from those areas, relatively speaking, states all over America have found themselves in an awful tight squeeze. In the 1980's the states in New England and California, because of their growth, were largely exempted from that because they were generating so much more money every year that they never knew what the rest of us were going through. But, if you have been reading the papers, the news around the country, you know that now 35 of the 50 states have actual operation shortfalls which are requiring them to dramatically cut budgets, or raise taxes, or both just to pay the bills.

You see this manifest, for example, in all the students that demonstrated outside Governor Cuomo's office the other day and broke the glass in the governor's office; a big state employee strike including mental health workers from the mental hospital in Montana; teachers in Washington on strike; and all over the country there is enormous upheaval. A lot of it was driven by the built-in huge inflationary cost of Medicaid and prisons in the 1980's, aggravated by the insistence of Congress in continuing to mandate new services in Medicaid, all of which are good things.

But Congress can mandate good things and pay their share of them and play games with the deficit through the Gramm-Rudman process that we can't play because all states are required to run on a balanced budget.

Now I have to put in a little plug for Arkansas if I might. While all states are required to run on a balanced budget, we are about the only state in the country which really does it. Here is what other states do who say they run on a balanced budget. The legislature meets with the Governor and they decide on how much money they think they are going to have and then they appropriate spending at that level and they spend that much for a year, whether the money comes in or not. Then at the end of the year, if they don't have enough

money, they either draw down from what they call a "rainy day fund" to pay the bills, or they have these drastic budget cuts, or they raise taxes. Just to fund the government they had before.

Now, what we do is entirely different from that. We estimate how much money we think we are going to have and we start spending at that level, but we prioritize our expenditures. For example, this year we had a Category A which is the money we spent last year, more or less. Of course anything we can cut out we reduce it by and if the federal courts have ordered us to spend anything we increase that. But basically it's what we spent last year.

Then we normally have a category which is like an A minus Category or a B. These are the things that we really think we ought to spend if we get any new money at all. And this year we have another category called B minus. These were other priorities that we really felt we ought to spend if we got that much money. Both pretty small really. Then we have a Future Operations Fund, it's the savings account. If we get anymore money than that, we save another \$15 to \$20 million. And then everything else the legislature wants to spend money on, we put into Category C and it will never get funded unless we strike oil.

Then, here is an example of how this works. When we were doing our budget we thought we would have enough

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“...the fastest growing parts of any state budget have been Medicaid and prisons.”

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money for A + B, and a 50-50 chance to do B minus, or B1 as we call it. Let's suppose, because there is a recession all over the country and revenues are down, we start off spending A plus 90% of B. But if two months go by and we don't make A plus 90% of B, I'll cut back and we will spend 80% or 70% or 60% of B. If I permit three months to go by as Governor after the legislature goes home in which spending is greater than revenues, I have committed a crime in Arkansas for which I can literally be prosecuted.

I have cut spending as much as six times in one budget cycle. No one likes it, but it's a lot easier shaving 1% here and 2% there and a half percent another place than waiting a whole year or two and having to cut 15% out of your budget. Then everybody squeals like a pig under a gate and they throw rocks at your office window. That is what is happening in New York. You are building these spending patterns.

But what grates against that system is, if judges and juries send people to the penitentiary, you still have to find a



place to put them. And if Congress puts any kind of mandate on you, you still have to pay for them. We have a two year budget cycle which means we just do our budget every other year and they do their budgets every year. What really kills us is when they lay it on us in the middle of our budget cycle. That is the second year of our budget. They put a whole new bunch of new mandates on that we could not have known about when we did the budget. That is what happened last year. That is when we had to virtually eliminate the medically needy program we were funding and cut back on a lot of other Medicaid services. I hated it but there was no way in the whole wide world we could have projected it. Congress, in the face of a national recession, with the support of the President, would add some new mandates.

I have no criticism of any of these specific programs. They are all good things. Increasing maternal and child health care coverage up to 185% of the poverty level for pregnant women and children through age one, going to 100% of the poverty level through age seven, moving up to age 18 a year at a time over the next number of years. Requiring more staffing in nursing homes and better training and complying with the minimum wage law. Keep in mind, we do it in Arkansas in the context of a balanced budget.

I tried to tell Congressman Waxman once and he got mad at me because he loves education. I told him he did not understand that every time he passed a new Medicaid mandate, you are mandating that we spend less on education. Now that may be a decision that the people of Arkansas should make, but I think their elected representatives ought to make it, not you.

So that is the background basically that we came into this session with. With a whole lot of new Medicaid mandates on the horizon, there is no way without the Medicaid Provider Tax, that will be paid for as 15% of the state contribution to Medicaid, that we could have done anything like what will now be done. As Lynn said about \$240 million being added to the Medicaid program. We put up \$30 million in state money and raised \$30 by the provider tax. We match it with \$180 million of federal money. For reasons I hope will never change, the Congress and administration have not yet prohibited us from doing that, and I hope they won't. Now there are about ten states doing what Arkansas is doing. That is how this money was raised and how it's going to be spent.

It will be used to raise the provider fees for almost all Medicaid providers.

You should know as taxpayers that 40% of all the taxes you pay to fund welfare would not have to be paid if the

people who owe child support and are legally bound to do it, paid. Forty percent of the total welfare budget for mothers and children would not have to come out of taxpayers' pockets if people who owe it and can pay it, paid it.

In the last two or three years, Congress has generated a lot of requirements to stiffen child support enforcement. For example, all states now have to go to automatic wage withholding by sometime in 1992. We went beyond that in Arkansas and we passed what I think are some of the toughest child support enforcement laws in the country. Among them is, if a woman shows up at a hospital to have a baby without a husband in tow whether she is single or has been abandoned, if she will identify the father we will put the father's name and social security number on the birth certificate and in Arkansas that creates a rebuttable presumption of paternity and enables

us right then to go after child support and puts the burden on the man. I think it's Constitutional since you can disprove paternity now with a blood test inconclusively which you used to not be able to do.

We have got to do some dramatic things. Government's don't raise kids, people do. I have no problem with helping folks and helping children who need it, but I think it's scandalous that in this country people think they can bring children into this world and father them and run off and leave it to the taxpayers to raise. We should stop this, and we're trying.

One of the things I heard in many places from a lot of you and I remember particularly the big meeting in Jonesboro and this came up was that the state's financial incentives to get doctors into rural areas were inadequate. So we substantially increased the rural medical practice student loan and scholarship program and adopted another rural physician recruitment and retention act which I hope will help us do our part at least to increase the availability of primary care physicians in rural areas.

We adopted a health insurance bill which I hope will have some impact on the huge number of people who have no health insurance in Arkansas. Now, a small business, one with 50 employees or less, which has not provided any health insurance to its employees within the previous 12 months is eligible to purchase a bare-bones health insurance policy which must at least include two physician visits and 15 hospital days a year and the option to get maternal and child health and just a couple of other things. All of the other mandates in state policy for health insurance are scrapped.

What we think is going to happen is that insurance companies who are writing these policies will probably write





about three policies all below the threshold of present mandates. One will just have the literal requirements of the law; one that meets the requirements of the law with the maternal and child care option; and, another which has a few other services. All below the present mandate.

We estimate that as many as 70,000 Arkansas citizens might be eligible for health insurance which can provide some basic coverage under this bill. Representative Dave Roberts of North Little Rock and Lt. Governor Jim Guy Tucker were particularly active in drafting this legislation. I think they did a real good job. We scanned the whole country and looked at what everybody else has done and tried to take the best of what they had done and listened to our folks to do a little better. I am optimistic about what this law may produce.

The legislature passed one or two other things I wanted to mention that will help the health care of the state although it is more preventive than not. One is a new set of domestic abuse laws to try to give people some protection in their own home against domestic abuse. I hate to tell you if you don't know, but you do if you do any emergency room work, that that is a huge problem in our state and nation. Under the old Arkansas law, a policeman virtually had to catch someone in the act of beating up his wife or child in order to really stop it. Under this system we have, we can get some injunctions and some protective relief which I hope will help us maintain safer homes.

You mention the seatbelt law and you would be amazed at how hard it was to pass that law. And you would be amazed at how many rural legislators have come back to me since the legislature broke up and said that the seatbelt bill I voted for was the most unpopular vote I cast. It was much more unpopular than the taxes I voted for.

I think it's very interesting and I have watched this in other states. This is not a liberal or conservative or republican or democratic issue. This is a cultural issue. It basically breaks down along rural and urban lines. The more rural an area, is the more likely people are to be against seatbelts and think they should have a right to die on the highway. The more urban an area is, the more people are likely to see their responsibilities to one another. Those of us who live in urban areas are much more likely to be aware of the fact that when someone has a wreck without a seatbelt their head goes through the windshield and they don't die, all the rest of us pick up the tab. So wearing a seatbelt is not just a responsibility for yourself and your family, but it helps to keep society's health care costs lower. But it's hard to make that dog hunt in the country because they don't think of running into somebody, they think of running off the mountain. It's very difficult and a fascinating thing.

Part of our emerging maturity as a nation, I think, without regard to our other differences, our philosophical or partisan differences, will be trying to isolate those areas in which we simply have responsibilities to the larger communities. You're going to see it in a lot of other areas.

I vetoed a bill that the NRA passed twice in the legislature. Their pre-emption bill which says no local community

can do anything to restrict any law related to guns or ammunition unless the state legislature has already done it. I said we have got all these drug gangs coming in and out of here and we never know what is going to happen and my legislature meets every other year. If I lived in New York I might sign a bill like that because the legislature is there all the time. I thought it was irresponsible from the point of view of the community interests' not knowing what is going to happen but having access to more information than most Arkansans about gang activity in our state and the movement of drugs in and out of the state and its relationship to violence, that I thought I should veto that bill.

It used to be that if you ever took a position adverse to the NRA you might as well let someone nail your scalp to the wall. I have heard very little adverse comments from my most ardent hunter friends about that. Just because I think people are now thinking as long as I can hunt and fish and do what I'm doing right, there are some things that it's o.k. to let the community's needs take its way over.

I personally think that sort of accounts for President Reagan's endorsement of the Brady bill, too. Because I can tell you I have a personal friend who owns a hardware store and sold a gun to a guy he had not seen in ten years and the guy killed six people within 12 hours. He had escaped from Fort Roots the day before. He asked the guy where he had

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"The only thing that was sort of alarming in a negative way about this session was the rise in the influence of the smoking and the tobacco lobby."

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been and he said he had been in California working. The owner said I have to ask you these questions to fill out this gun control form. The owner asked if he had ever committed a felony or been in a mental hospital. The guy said no. Under present law, the gun owner puts that form in his drawer and keeps it in case someone wants to look at it. The owner had no way to verify it. He had known the man ten years ago. The guy had gone to Vietnam and had a mental breakdown as a consequence of his service to his country. He was not responsible for what he did. But if we just had three days where he could have checked the information or a place where he could have called to find out, I think it would have made a big difference.

There either needs to be a registry of convicted felons and people who are out of mental hospitals that can be checked instantaneously or some sort of system to do that. It



won't measurably interfere with anybody's right to hunt or pursue their sporting interest.

The other issue where this became really big was the smoking area. Dr. Jones and I tried to pass an indoor clean air act, but they just killed us. Basically what we wanted to do is to give the State Board of Health the authority to establish areas where no one should be smoking in the community interest. Such as grocery stores or other appropriate places inside. The argument was that some of this is being done anyway and then they tried to stick us with their version of the pre-emption thing which was to say that no city could adopt an ordinance more stringent than the state legislature, had adopted. This would have had the effect of prohibiting anybody from doing what Little Rock has already done which is to ban smoking in grocery stores and other places. So we lost.

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"It's the one time in your life where doctors would have been glad to see more lawyers in the legislature."

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The other thing that happened and I must say I think this was the best legislative session in my lifetime for the reasons Lynn said. The only thing that was sort of alarming in a negative way about this session was the rise in the influence of the smoking and the tobacco lobby. It is obvious that they are facing a decline in smoking in America.

These companies have adopted a three-prong strategy. One of which I agree with is the diversifying into other areas. A lot of them are becoming food companies, for example. They are trying to generate more revenue and keep their folks working. That is the laudable thing to do.

The second part of their strategy is to sell more cigarettes overseas where the cultural tide is not running against them and where incomes are rising. So you have smoking on the rise in a lot of Asian countries where incomes are going up and there is no real health awareness.

The third part of the strategy is to give a whole lot of money to the state legislators and governors and other people with campaigns and then try to get legal action to put some brake on and slow down this great cultural trend to reduce smoking. This so-called Smoker's Bill of Rights passed the House where there are only like 14 or 15 lawyers out of 100 people. It's the one time in your life where doctors would have been glad to see more lawyers in the legislature. They just got up there and said, "this just says you can't be fired for smoking off the job."

But what it said was, no employer may fire, refuse to hire or otherwise disadvantage any employee for smoking in non-working hours. Let's take Phillip's Food For Less. I don't think they would mind me using them. They are a northwest Arkansas grocery chain and they don't hire smokers now because one of their fringe benefits is a term-life insurance policy for every employee. It's a great deal. The policy equals two years of their salary. For any of their employee's who die, the family receives another two years of pay. They found there was a 20% differential in life insurance premium costs between the smokers and the non-smokers so they did that to cut down on costs. They also found that actual utilization of their health insurance program was 40% higher among their smoking employees than their non-smoking employees. They didn't fire anybody and there is no company giving differential health insurance yet, but I hope there will be soon. But they sure didn't want to assume those costs anymore than you do.

The other real landmine in there was the "otherwise disadvantage" language which can be read and could generate a whole lot of lawsuits to require people who do not now have smoking areas inside their office building to do it for their employees in non-working hours on the theory that you're disadvantaged if you have to walk outside in January to smoke. So they passed it and I vetoed it. Two or three times there was a serious attempt at over-riding the veto. They eventually attached it to the Health Department's budget. Then we got an opinion from Attorney General Winston Bryant, who did a good job on it and gave me about a two hour turn around, which said that was unconstitutional, so they took it off.

But this is a fight which is not yet done. There are a lot of smokers who feel like they have a right to do it. The issue is not if they should have a right, but how are we going to reconcile society's interests and not be exposed to ancillary smoke and the enormous burden of our health insurance costs that are astronomical because we don't practice elemental prevention in a whole range of areas. I do want you to think about that.

One other issue I would like to mention is that the Indigent Health Care Advisory Council has changed in its name and mission to the Health Access Council and we are going to try and find ways to provide access to health care to people in rural areas who don't have it and to provide coverage for people who don't have it and especially to beef up our efforts in rural areas. We also passed a law to appoint member of the Board of Health from a rural position. I think that will be a very good thing.

I have already talked longer than I meant to but let me just say a couple of other things.

We raised some money in this session. In addition to what you paid we took a half cent on the sales tax and put it into a trust fund for education to fund a whole range of reform. The State Chamber of Commerce asked us to raise the corporate income tax at half a percent on the 1500 wealthiest corporations in the state to finance a reorganiza-



tion of the vo-tech schools and community colleges. It is absolutely critical. We have got to get 20,000 more people in these two-year programs to get our per capita income up to the national average. Younger workers who just graduate from high school and go to the workplace are getting murdered. Their incomes have gone down 25% in 15 years. Basically nearly everybody needs two years beyond high school, not a four year degree, but two years beyond high school. All these companies in all your communities need access to an institution that gives continuing educational training.

Then we adopted the highway program. Every one of those taxes passed was between 76 and 100% of the vote in both houses of the legislature with the majority of the republican as well as democratic legislators voting for it. I think the reasons were pretty clear. First, you can't move a state forward without investments. Second, we put all this money in trust funds. You don't have to trust us to spend it right, it's in the law how it is going to be spent. And because of our balanced budget system, we did not have to raise one red cent to run the government that was present before the legislature met. Not a penny.

Now, I have to say this. If you hadn't come with the Medicaid thing, it would have been tougher because of all the

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“The other thing we are trying to do is put more choice in government services and make the whole government sort of more user friendly.”

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federal mandates. We absorbed all the extra prison costs and a disproportionate amount of health care cost and still didn't raise any money just to pay for what we were doing before the legislature got there.

I think that is the way we need to go. Everybody knows we need to invest more in our future, but we don't need to spend more on our present for paying off the past while we're doing it. And I don't think you should have to put your faith that you're going to pay your money in taxes into any number of politicians that just do what they say they are going to do. I like the trust fund confidence so that the money can be legally secured.

I just want to say one more thing about child support. We also have tried to do some other things with your money. We have tried to increase the responsibility that we impose on people who benefit from taxpayer dollars. For example, starting next year no 16 year old can get a drivers license

who's not enrolled in school. If you drop out for no good reason, you lose it. By 1993, you have to have a C average or a certificate from school saying you're trying and doing your best as a student and just can't do any better and you're entitled to drive because you are doing your best.

If the local prosecutor refuses to enforce this, the school board can go to court and mandate that the prosecutor revoke the drivers license. I think that is important. I could triple

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“We have a real chance at making the 1990's a decade of destiny...”

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your taxes, but if the kids don't go to school and do right it wouldn't help. Arkansas is the only state in America where we can fine parents if they won't show up for a teacher's conference when their children are in trouble. We have got to demand that people who get taxpayer money have got to behave right. If the people don't behave and act right, then the money is wasted.

The other thing we are trying to do is put more choice in government services and make the whole government sort of more user friendly. We should re-structure it the way a lot of corporations have by eliminating middle layers of management, putting more people in direct contact with constituents, and regulating less and helping more.

We also passed a program which I think will be a lot of interest to a lot of you which will now be more sweeping than any state around us. The program is Elder Choice and it will enable us, thanks to a waiver we got from the federal government, to take money that used to be spent only on nursing homes when an older person becomes eligible for nursing home care, can now let that person decide whether to spend it on nursing home care, home health care, personal care, pay a nurse to work at the senior citizens center to turn it into an adult day care center, and for transportation.

I think this is going to be a big issue. People over 80 are the fastest growing segment of the population. It is a real civil rights issue. People who have good minds and strong spirits but weakening bodies should have the maximum number of choices they can in the way they live their remaining years.

I think our state is going in the right direction. I think all of your legislators did a terrific job. It was just the train I was riding on and when it got going it just got better and better.

I hope when you go home you will thank your legislators in support of this. We have a real chance at making the 1990's a decade of destiny for this state because of what they did.

Thank you very much.



**Address by the Honorable William Dannemeyer  
U.S. House of Representatives  
39th District, California**



Good afternoon ladies and gentlemen.

I have heard it on good authority that your president, Dr. Jones, is a collector of rocks. I'm not sure why, maybe Mrs. Jones can put some light on that. It's my privilege to bring a little memento to him. My wife and I went to Germany for Easter vacation one year ago. I always told her that if the Berlin Wall ever came down I wanted to be there to watch it because it is something that is affecting the lives of every American and every citizen in the world. The repercussions of what bringing down that wall means to the world. It means that Communism as an economic system is recognized for the failure that it is and a lot of other things. Dr. Jones, I want you to know that I took a hammer and chisel and chiseled a piece of rock out of that wall and I just happen to have a piece of it with me and I want to present that to you today.

You may wonder, why is this Californian in Hot Springs, Arkansas? Well, there's a story about that and I guess I will get to that shortly.

In my business it's always encouraging for me to find out a little of the respect of which I'm held as a member of Congress. In the campaign last fall, this concept was brought to my attention because a volunteer worker in my campaign office received an anonymous call from an unidentified male

voice. And this male voice said, "Let me speak to that big hog in the public trough." She hesitated a moment and said, "Sir, if you mean the Congressman, you will have to show a little more respect than that." The male voice said, "Lady, I didn't call to quibble. I just called to say that I wanted to contribute a thousand dollars to the Congressman's campaign for re-election." And she said to him, "Just a minute sir, I think I see the big hog coming through the front door right now."

As to why a member of Congress from southern California would be a long way from home, let me tell you the respect and esteem I have for the president of your medical society, Dr. Billy Jones. It's been my privilege to serve on the Health and Environment Subcommittee for the last six terms in the House. In that capacity, the committee has the responsibility of developing a public health policy at the federal level for dealing with the AIDS epidemic. I'm talking to a lot of physicians here who know full well that our primary means of interfacing with any epidemic is at the local level. That is the county and the state, not the federal government.

But the federal government does set certain policy guidelines. The NIH, as we know, is deeply involved in research into many diseases that we hope to find cures. The



CDC, of course, collects statistical information that relates to how and what diseases are in what portions of the nation.

I was aware as any citizen in the country of the existence of the AIDS epidemic, and let me say as a Californian that we're unique in a lot of ways. We have a lot of things. We are the biggest state in the union. One of the unenviable distinctions of California is that we are the state with the second highest total of AIDS cases in America, surpassed only by New York state. New York has a little better than 20% more cases than California.

When I, as a member of the committee, dug into this issue rather extensively in the mid 80's, around 1985 I came to the conclusion that really what we are dealing with is the first politically-protected disease in the history of the country.

You people in the great state of Arkansas, I suspect, haven't had a lot of involvement. The number of cases places you down among the lower tier in terms of the incidents of this disease in your population base. But nevertheless, your medical society, to its credit, has treated this as a public health issue and not a civil rights issue.

I was on a program out in Los Angeles a few years back. I think Ted Koppel was the moderator of it on ABC. There were about a dozen of us on the program. I think I was one of only two who wanted to treat AIDS as a public health issue and not a civil rights issue. After the program, your president, Dr. Jones, called me on the telephone. He said, "Congressman, the things you are talking about, in terms of a policy of treating this as a public health issue and not a civil rights issue, is absolutely right." That's how our friendship began.

The American Medical Association, which is the voice of organized medicine in America, in my humble opinion with all due respect to the members of that association, has not exhibited the leadership to this country that should have been forthcoming from that great institution in American society. It has been used as a vehicle for treating this disease as a civil rights issue, not a public health issue.

But there's one man in this country, and that's your president, Dr. Billy Jones, who refused to accept that bias and how this nation, through its medical officials, would treat this disease. He went as an unelected delegate to the convention of the American Medical Association in December of 1989 and through the style that he exhibits of cajoling and badgering, and just loving people to death, he was able to convince the delegates of the American Medical Association to adopt a resolution that didn't say anything new. It just said, "Enforce the public health laws of America the way we have traditionally enforced the public health laws dealing with disease in general." That's all it said.

What's profound about recommending that every state in the Union should have in place reportability and contact tracing for HIV carriers? Well, the profundity is that for the last five years as a member of Congress I have been saying the same thing but the political left has been ridiculing and beating up on me. But when Dr. Jones got the AMA to adopt

this resolution, which expresses the sense of the American Medical Association, he gave me respectability. And for that I'm grateful.

So when he asked me as a favor six months ago to come to Hot Springs, Arkansas, to speak to this wonderful group of people, I said I owe the gentlemen a favor, so here I am. I'm here to pay respect to this leader in America. Really, one man made a difference. That resolution, believe me, has changed the whole scope of this debate across this land.

Let me tell you how the staff of the American Medical Association has prevented that policy from being implemented at the federal level. We had a bill going through the Congress last year. I offered a series of amendments candidly called for any state getting money to implement prison testing, and testing people in high-risk areas and so forth. Those amendments were adopted. But the one amendment that needed to get in there and belongs in the law, is reportability and contact tracing for HIV carriers. Notwithstanding the adoption of this resolution at the AMA, the staff of the AMA came back with a letter opposing my amendment.

They justified that bias on the basis that for the federal government to mandate reportability and contact tracing, would be an invasion of states' rights. At this late date in the evolution of American medicine and the society that we know and love as America, and the expansion of medical

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“...your medical society, to its credit, has treated this (AIDS) as a public health issue and not a civil rights issue.”

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care since 1965 through Medicare and Medicaid, for the American Medical Association staff to tell the Congress of the United States that they don't want a policy implemented because it results in the violation of states' rights, is kind of like Brooks Robinson, a member of the Hall of Fame, trying to say that the manager of the Baltimore Orioles doesn't want to travel anymore. After having spent his whole political career traveling around the country playing the great game of baseball.

It's just another illustration how, at this late stage in the epidemic, there is still an inclination to treat this epidemic as a civil rights issue and not a public health issue. But it is changing and maybe through your leadership, doctor, you can finally nudge it over to the point where the AMA will come forward and say cut it out. The civil rights of the



uninfected are at least entitled to the same equal protection as the civil rights of the infected.

Another thing I wanted to discuss with you today relates to what's happening at the federal level. I always like to bring good news and then news that I would say could be better described as in need of improvement.

The good news relates to how we Americans look at the world today and hold our heads high. What our President and our military leadership did in the Middle East war has changed the whole course of America and military history. The magnificent performance of the leadership of President Bush in organizing and assembling 28 nations interfacing with Saddam Hussein is a master stroke of political organization and it should be recognized as such and we should praise President Bush and Secretary Baker for that. What has come out of the Middle East war is nothing less than a new horizon in terms of warfare and I pray to God that we will never ever have another war, as I think any thinking person does. But, when you read history, the Bible says there will be wars and rumors of wars. And sadly, these things happen. People who are prepared to defend themselves and their freedom, I think, have a chance of keeping it.

The political left in America ridiculed the strategic defense initiative that was proposed by President Reagan in 1983. And now the performance of the patriot missile makes glowingly clear that a bullet can intercept a bullet. Incredible that that has happened, but essentially that is what the patriot has done. So it is imperative that America continue to develop the strategic defense initiative to protect ourselves from would-be dictators around the world who want to perhaps go the road that Saddam Hussein has tried in his leadership in Iraq.

Another lesson from that struggle is that our political leadership learned something from the Vietnam experience. That is to say if you're going to commit the armed forces of this country to a war, commit them to win that war with the tools that are available and the political leadership stay out of it and let the military do its job. President Bush learned that lesson.

I received a beautiful letter from a constituent of mine that was sent to a California navy flyer from the Vietnam war era who flew 161 missions. It was to the President and he really just said thank you Mr. President for exercising this ghost, this feeling on my part that as a Vietnam veteran, that my service to the country that I love has been in vain. It hasn't been because you have demonstrated a lesson that you

have learned and I thank you for that. I think the veterans in this room know exactly what I'm saying.

Our men and women came back from the Middle East and were recognized around the country for the heroes that they are. They fought, and some of them died and will not return and to them we are thankful and our hearts go out to their families.

America has said we stand for certain values and the leadership we have exhibited, I think, speaks well for our nation as a people and the ability to hold our heads high and say America has put the ghost of Vietnam behind us. I think that is a great thing for all of us.

On the subject of things that need improvement - let me suggest to you that when you look at the expansion of Medicaid spending and Medicare spending in just the era from 1985, Medicare was consuming \$65.8 billion. In 1990, it has gone up to some \$96.6 billion. That's roughly a 50% increase. In 1985, Medicaid spent \$22.6 billion. In 1990, that had gone up to better than \$40 billion, again over five years a little less than a 50% increase. The expansion of Medicare and Medicaid at the federal level is proceeding far in excess of the rate of inflation and people are scratching their heads as to what we can do about it.

Some say health costs in this country are out of control and are devouring a larger and larger share of federal and state budgets. In 1990 for instance, consumption for all spending for health care was about 12.2% of GNP. In 1989 it consumed about 11.6% of GNP. This is the highest percentage of GNP of any nation in the western world. And people are scratching their heads and asking why is this so.

Then to answer that question with respect to Medicaid, I think we have to understand a little bit about how Congress works on this issue. I have a list here of the last five years beginning 1986. I won't read you all the details of what federal action mandated state's to do in the area of Medicaid expansion. The mythology at the federal level in 1986 and 1987 was to make certain expansions in Medicaid optional. Then, in 1988, 1989, and 1990 to come along and require that those optional expansions be made mandatory.

The game that is being played today, very candidly, is that there is perceived to be a crisis in medical care in America. We have these 35 million Americans without health insurance and we need to have a federal response. Senator Kennedy and my colleague from California, Henry Waxman who serves on the Health and Environment Subcommittee of which I'm vice chairman, their solution is to put a requirement on all employers in this country that on the employers' nickel we provide health insurance for all these





uninsured Americans.

But here is the game that's played, and I'm not speaking in a disparaging sense because it's all part of politics. Mr. Waxman, the chairman of the committee, quite candidly, has the proxies of all the democratic members of that committee in his pocket. Essentially, what he and his staff decide to be the expansion of Medicaid in a particular year, that's about what it is going to turn out to be.

You may have heard that we had a major deficit reduction package last fall. This is the package that President Bush ended up approving when he broke his pledge to the American people saying, "Read my lips, no new taxes." That package had in it \$160 billion of increased taxes over the next five years. This expansion of Medicaid spending has become so profound in America today that 49 governors of the Union have signed a letter to the Congress of the United States saying, "Cut it out. We can not afford to continue to provide the funds at the state level." As you know, the federal government pays about half for Medicaid and the states have to match that with their half. This expansion is literally driving some states to the verge of bankruptcy.

For instance, in Arkansas the proceeds of a new tax will be dedicated to the Medicaid program even though Governor Clinton would prefer to direct the revenue into educational programs.

After learning that deep education cuts were insufficient to close the deficit, Mississippi decided to raise money for its Medicaid program by selling \$7.5 million worth of booze from an Alcohol Beverage Control warehouse. Not a bad idea I guess.

In Pennsylvania, a group of hospitals who treat Medicaid patients borrowed \$350 million from Pittsburgh's National Bank in order to fund the state's share of the program.

Because of the explosive growth of Medicaid spending, Delaware is unable to expand any of the state programs this year.

And on and on it goes. I have a list of seven or eight governors and I think the governor of South Carolina put his finger on what's going on clinically in this country. There's no question about it. Some members of Congress have used Medicaid as a back door attempt to get a national health insurance program. That's what's going on. There's a crisis in the states of the union. Twenty-nine states have cut more than \$8 billion out of their enacted budgets and 26 states have approved \$10.3 billion in tax increases. The largest cumulative increase since the National Governors Association initiated its survey in 1978. What can we do about all this?

I met with the representatives of the National Governors Association in Washington and we have a bill that we are all ready to introduce. It has five elements in it. I'll just read the captions to give you a flavor of it: (1) Two year delay of the mandatory implementation of 1990 Medicaid mandates; (2) The protection against disallowances for good faith compliance with requirements; (3) Authorizing waiver of nursing home reform requirements; (4) Early periodic screening, diagnosis, and treatment; and (5) Adjustments of federal

income official poverty line for states with per capita income below the national average. That is a summary of its provisions.

Let me tell you a little bit about how politics works in Washington. If any of us are serious about a legislative proposal, it has to have bipartisan support. Otherwise it will not go anywhere. Washington, DC, is so partisan that if the republicans suggest something should be done the natural inclination is for the democrats to find a reason not to do it and vice versa. That's not necessarily wrong. That's just the way we sharpen and focus issues in American politics. But if you want to get something done legislatively speaking, you need a bipartisan approach to it.

I have been striving to get a democrat from the House to co-author this legislation. Well, I have been struggling for the last month to get it done and I can't find any. I guess another reason I have come to Arkansas is because you have three democrats serving from Arkansas in the state House of Representatives in Washington. Will you please ask one of those people to join in on this bill to support the governor of your state along with 48 other governors who have said to the Congress of the United States, "Cut it out."

I don't know what kind of response you will get when you talk to my good friend Bill Alexander or Beryl Anthony. I'm sorry to say I haven't gotten to know your newest

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"Congress is the institution that controls spending in this country and don't let anybody ever tell you otherwise."

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member of the House. As I explained to Dr. Jones, if you don't come from the same state or serve on a committee you don't get to know a fellow that well. Maybe you can get one of those good democrats from this state to join in on this legislation because only by getting a bipartisan approach to hopefully slow this thing down do we have a chance of relieving some of the pressure on the states of the union.

My governor in California, Governor Wilson, has just proposed a new 6% state sales tax. Currently, he wants to add another cent and a half tax to the people of California. There's one thing I have learned in my experience in life and politics and that is that we are not under taxed as a people, we're simply spending too much money. I can say that as a Californian and I can say that as a member of the United States Congress.



Somebody alluded to the fact that I started out my career in politics as a democrat, that's true. I can say to those who may question why I changed that wisdom should not be discarded merely because it comes at midpoint in life. There may be some in this room to whom that may apply given the fact your state legislature is controlled by democrats.

To put this issue of runaway spending in perspective, we Americans need to understand something at the federal level as well. We're taxing ourselves at the rate of about 19% of GNP, close to historic high. The problem is we're spending at the rate of 25% of GNP which is also very close to an historic high. Just two years ago the federal government was spending about 23% of GNP at the federal level.

Raising taxes is not the answer to this problem because what the history of raising taxes in the decade of the 80's shows is that for every dollar you raise you get about \$1.60 of additional spending. A lot of people in this country say they would be willing to pay more taxes provided you would apply that to reduce the deficit. You hear that from a lot of folks. I think most of us love our country and we recognize that in a free society you have to pay taxes because that's part of the price of civilization. I would like to be able to say to you that we would use that additional revenue from raising taxes to reduce the deficit.

In case you want to know what the deficit is this year, to me the measure of the deficit is not what some of the people in Washington print it to be. The measure of the deficit is how much we're going to increase the national debt by. This year we're scheduled to increase the national debt by four-tenths of a trillion. Next year a similar amount. As early ago as 1980 we crossed the threshold of a trillion dollar national debt. In 1990 we broke beyond that for three trillion. If we continue on this current course, we'll cross six trillion before the end of this century.

The belief or premise on which Washington is working today is that there is no limit to which we can escalate the debt bubble in America and the world. I don't believe that for a moment and the common sense of the American people tells us not only do we have a fiscal problem in this nation, we have a fundamental moral problem in our country. The moral problem is where do we, who are living today, get the authority to spend and consume and transfer to an unborn generation the duty of pain for what we're consuming today. And when you add to this the paradox in our American society that not only are we visiting this debt on an unborn generation, but we have a policy rampant in America where

we are killing 1.3 million unborn children a year in the name of abortion on demand because we say it's not quite convenient for us to bring them into the world. Some very interesting and moral questions for our society.

I mention this because Medicaid and Medicare are important to all of us, but the debt bubble is also important so what can we do about that? There is a tendency on the part of the American people to believe it's President Bush's fault or it's President Reagan's fault or it's President Carter's fault or President Ford's fault. When it comes to foreign policy, Presidents control what happens in our world because that person speaks for all of us.

When it comes to spending, Congress is where the action is. Congress is the institution that controls spending in this country and don't let anybody ever tell you otherwise. What we are getting out of the Congress of the United States in the area of runaway spending is a tragedy for all of us to watch unfold each day as we watch it happen. And it's going to go on and on and on until the people of this country decide it's been enough and we decide to throw the big spenders out of there.

I don't sense that that awareness is quite here yet, even though we are in a recession. A recession is defined as your neighbor losing his job and a depression is defined as I or you losing our jobs. Well, a lot of us are still working and so I'm not sure we have reached a point as a people where we will focus on those big spend-

ers who are, as I say, leading us into this debt bog. Someday it's got to happen that the people in this nation will rise up and say enough.

If you're interested in where to identify them, the National Taxpayers Union annually publishes an analysis of all of us serving in Congress on the issue of spending. You want to know who the big spenders are, there are about 135 of them there who have never met a federal spending program they didn't like. And they never met a regulation they didn't really want to embrace. There are three things that define liberals in American politics. The first is if it moves, regulate it. Second, if it grows, tax it. Third, if it makes a profit, investigate it because it must be doing something illegal. You can define a liberal on the political left with that interesting analysis every time.

Well ladies and gentlemen, thank you for the privilege of coming here and visiting with you today. It's been a privilege to be here in your great state to pay my respects to your outgoing President, Dr. Bill Jones.

Thank you very much.





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# 1991 Arkansas Medical Society Annual Session

<u>Officers</u>		<u>First Session</u>	<u>Second Session</u>				
Speaker	John Crenshaw	present	present				
Vice Speaker	Kelsy J. Caplinger III	present	present				
President	William N. Jones	present	present				
President-elect	George W. Warren	present	present				
1st Vice President	Michael N. Moody	present	present				
Secretary	Charles H. Rodgers	present	present				
Treasurer	James M. Kolb Jr.	present	present				
<u>Councilors</u>							
District 1:	J. Larry Lawson	present	present				
	Merrill J. Osborne	present	present				
District 2:	John E. Bell	present	present				
	Jim E. Lytle	-	present				
District 3:	L. J. P. Bell	present	present				
	Hoy B. Speer Jr.	present	-				
District 4:	Lloyd G. Langston	present	present				
	Paul A. Wallick	present	present				
District 5:	Wayne G. Elliott	present	-				
	Cal R. Sanders	present	present				
District 6:	James D. Armstrong	present	present				
	F.E. Joyce	present	-				
District 7:	Ronald J. Bracken	present	present				
	Thomas H. Hollis	-	present				
District 8:	Glen Baker	present	present				
	David Barclay	-	present				
	Paul Cornell	present	present				
	Warren Douglas	-	-				
	Charles Logan	present	present				
	R. Jerry Mann	present	present				
	Harold Purdy	present	-				
District 9:	Robert H. Langston	present	present				
	David L. Rogers	present	present				
				<u>Councilors</u>	<u>First Session</u>	<u>Second Session</u>	
				District 10:	A. C. Bradford	present	present
					Gerald A. Stolz	present	present
					Morton C. Wilson	present	present
				<u>Past Presidents</u>			
				1979-1980	A. E. Andrews	present	-
				1971-1972	C. Stanley Applegate	-	-
				1985-1986	John P. Burge	present	present
				1983-1984	Asa A. Crow	present	present
				1964-1965	C. Randolph Ellis	present	-
				1969-1970	Ross E. Fowler	present	present
				1951-1952	Charles R. Henry Sr.	-	-
				1982-1983	Morris M. Henry	-	present
				1988-1989	John M. Hestir	-	present
				1987-1988	W. Ray Jouett	present	present
				1976-1977	Albert S. Koenig Jr.	present	present
				1977-1978	W. Payton Kolb	present	present
				1980-1981	Kemal E. Kutait	-	-
				1986-1987	Ken Lilly	present	-
				1967-1968	Joseph A. Norton	-	-
				1974-1975	Ben N. Saltzman	present	present
				1981-1982	Purcell Smith Jr.	-	-
				1968-1969	H.W. Thomas	-	-
				1975-1976	T. E. Townsend	-	present
				1963-1964	Joe Verser	present	present
				1972-1973	C. Robert Watson	-	-
				1989-1990	James R. Weber	present	present
				1984-1985	Charles F. Wilkins Jr.	-	present
				1973-1974	John P. Wood	-	-
				1978-1979	George F. Wynne	-	present



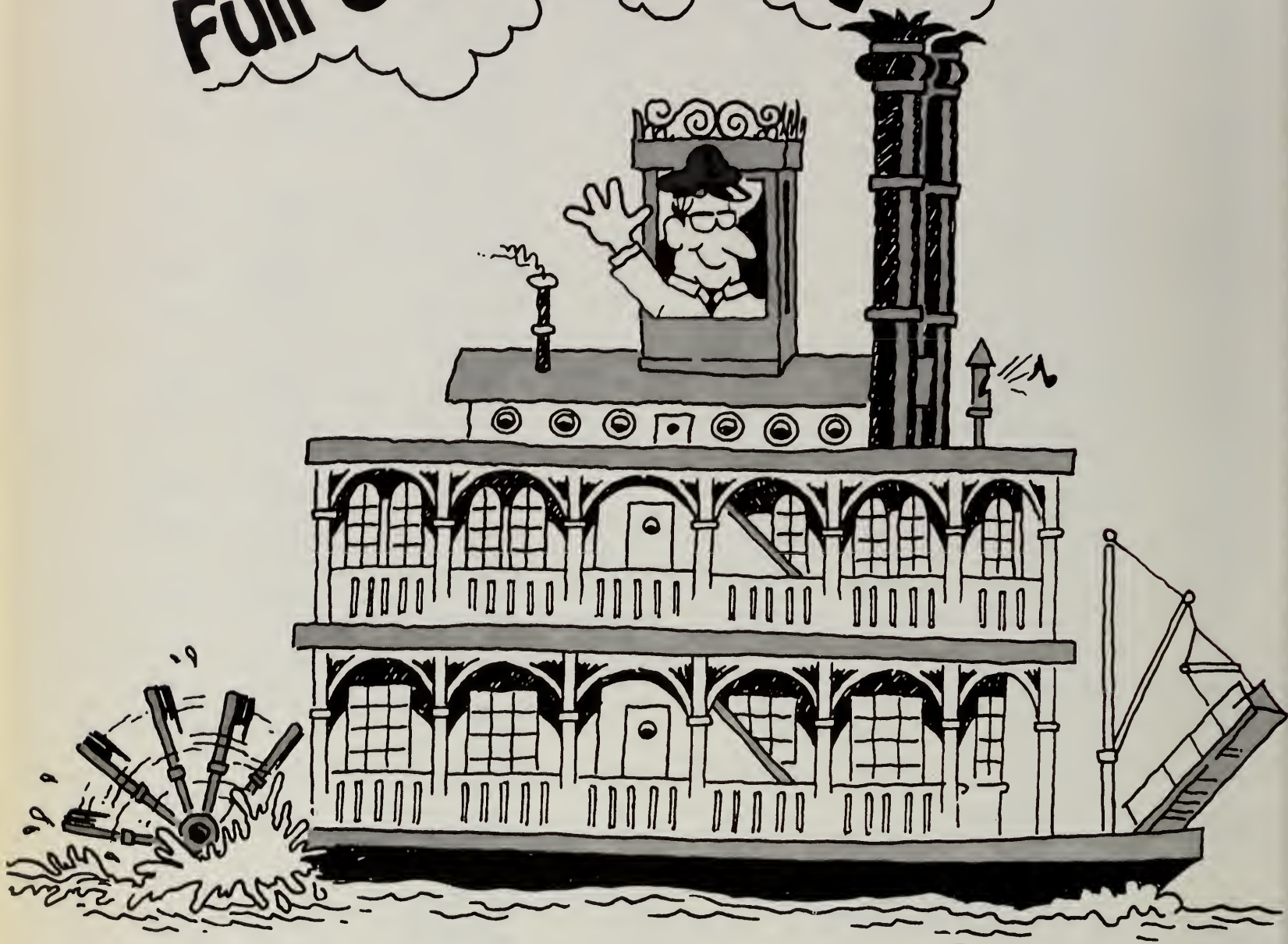
# House of Delegates Composition

	<u>Delegates</u>	<u>First Session</u>	<u>Second Session</u>
Arkansas (1)	Dennis B. Yelvington	-	-
Ashley (1)	Curtis Ripley	-	present
Baxter (1)	Robert L. Baker	present	present
Benton (2)	William T. Summerlin	-	present
	Stephen L. Goss	-	present
Boone (1)	John T. Troupe	present	present
Bradley (1)	Joe H. Wharton	present	present
Carroll (1)	Oliver Wallace	present	present
Chicot (1)	Tom Tvedten	-	present
Clark (1)	Noland H. Hagood	-	-
Cleburne (1)	J. Warren Murry	present	-
Columbia (1)	H. Scott McMahan	-	-
Conway (1)	NOT REPRESENTED	-	-
Craighead/ Poinsett (5)	Jerry D. Blaylock	-	-
	Ben Owens	-	-
	Joe H. Stallings Jr.	present	present
	Don B. Vollman Jr.	present	present
Crawford (1)	NOT REPRESENTED	-	-
Crittenden (1)	Steve P. Schoettle	-	present
Cross (1)	NOT REPRESENTED	-	-
Dallas (1)	Don Howard	present	present
Desha (1)	Howard R. Harris	present	-
Drew (1)	Harold Wilson	present	present
Faulkner (1)	J. J. Magie	present	present
Franklin (1)	David L. Gibbons	present	present
Garland (5)	Cecil W. Cupp	present	present
	James L. Gardner	present	-
	Doane M. Newton	-	-
	Mark Russell	present	present
	Rhetta M. Stecker	present	-
Grant (1)	NOT REPRESENTED	-	-
Greene/Clay (1)	Roger Cagle	present	present
Hempstead (1)	Dwight Williams	-	present
Hot Spring (1)	Bruce K. Burton	present	present
Howard/Pike (1)	Joe King	-	-
Independence (2)	Lloyd G. Bess	present	present
	J.R. Baker	-	-
Jackson (1)	NOT REPRESENTED	-	-
Jefferson (4)	Simmie Armstrong Jr.	-	-
	Lee A. Forestiere	present	present
	David Jacks	present	present
	Anna T. Ridling	present	present
Johnson (1)	NOT REPRESENTED	-	-
Lafayette (1)	Sanford E. Hutson	present	-
Lawrence (1)	Ralph F. Joseph	-	-
Lee (1)	NOT REPRESENTED	-	-
Little River (1)	Robert D. Dalby	-	-
Logan (1)	John R. Williams	-	-
Lonoke (1)	Jerry C. Chapman	-	-
Miller (3)	Donald L. Duncan	-	-
	William B. Harrell	present	present
	Herbert B. Wren	present	-
Mississippi (1)	Eldon Fairley	present	present
Monroe (1)	Neylon C. David	present	present
Nevada (1)	Charles Vermont	-	-
Ouachita (1)	William D. Dedman	present	present
Phillips (1)	Robert Miller	present	present
Polk (1)	Byron Page	present	present
Pope (2)	Kevin Beavers	present	present
	Kelly H. Meyer	present	present

	<u>Delegates</u>	<u>First Session</u>	<u>Second Session</u>
Pulaski (29)	Durwood B. Allen Jr.	-	-
	John W. Baker	-	present
	Raymond V. Biondo	present	present
	Amail Chudy	-	-
	Gilbert O. Dean	present	present
	Marlon Doucet	-	-
	Jim English	present	present
	Charles P. Fitzgerald	-	-
	James L. Hagler	-	-
	Edwin Hankins III	-	-
	Fred O. Henker III	present	present
	D. Andrew Henry	-	-
	Marvin Leibovich	present	-
	Fred Nagel	present	present
	George A. Norton	-	-
	Walter O'Neal	present	present
	J. Mayne Parker	-	-
	John D. Pike	-	-
	Carl J. Raque	present	present
	John F. Redman	present	present
	William Riley	-	-
	Ashley S. Ross Jr.	-	-
	Bruce E. Schratz	-	-
	Robert F. Shannon	present	present
	Frank M. Sipes	-	-
	William L. Steele	present	present
	Wanda J. Stephens	-	-
	Robert Valentine Jr.	-	-
	Thomas Wortham	present	present
Randolph (1)	NOT REPRESENTED	-	-
Saline (1)	Marvin N. Kirk Jr.	-	present
Sebastian (9)	Jimmie Atkins	present	-
	Robert Hughes	present	present
	A. Samuel Koenig III	-	present
	John R. Lange	-	present
	Sumer A. Phillips	-	-
	Eugene F. Still	present	-
	Jerry R. Stewart	-	-
	John R. Swicegood	-	-
	Paul I. Wills	-	present
Sevier (1)	Jonathan Hoyt	-	-
St. Francis (1)	NOT REPRESENTED	-	-
Tri-County (1)	A.M. Grasse	-	-
Union (2)	Wayne G. Elliott	-	present
	Bert Dougherty	-	-
Van Buren (1)	John A. Hall	-	-
Washington (5)	Hershel Gamer	-	present
	Anthony Hui	-	present
	William McGowan	present	present
	Linda Markland-McGee	present	present
	William B. Nowlin	present	present
White (2)	Kenneth R. Meacham	present	-
	Daniel S. Davidson	-	-
Woodruff (1)	James E. Rowe	-	-
Yell (1)	James L. Maupin	present	-
Resident Physician Section (1)	NOT REPRESENTED	-	-
Medical Student Section (1)	Katherine Henry	-	present



# Full Steam Ahead



**115th Annual Session  
Proceedings of the House of Delegates  
of the Arkansas Medical Society  
April 25-27, 1991**

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# House of Delegates

## First Session - April 25, 1991

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Speaker of the House John Crenshaw called the House of Delegates to order on Thursday, April 25, 1991, at the 115th annual meeting of the Arkansas Medical Society. He called upon Vice Speaker Kelsy Caplinger to give the invocation.

The Arkansas National Guard presented the colors and Mr. Horst Fischer, general manager of the Arlington Hotel, greeted the House.

Speaker Crenshaw introduced the following guests and asked each to come to the podium and address the House: Mrs. Joe Ed Smith, Southern Region, American Medical Association Auxiliary; Mrs. David Williams, president, Arkansas Medical Society Auxiliary; and Mrs. Charles Rodgers, president-elect, Arkansas Medical Society Auxiliary.

Speaker Crenshaw asked A. E. Andrews to come forward and introduce John L. Clowe, M.D., from Schenectady, New York, the Speaker, House of Delegates of the AMA.

Speeches from the House of Delegates appear throughout *The Journal*.

At the conclusion of Dr. Clowe's speech, he was presented with an Arkansas Traveler's Certificate. Dr. Clowe in return presented Dr. Jones with a rock from the new AMA building as a memento of his year actively working with the AMA and serving as President of the Arkansas Medical Society.

Speaker Crenshaw announced there were 94 voting in attendance.

Upon a motion the House voted to approve the minutes of the 114th annual session as printed in the June 1990 issue of *The Journal of the Arkansas Medical Society*.

Speaker Crenshaw asked President Jones to come forward and assist Mrs. David Williams and Mrs. Jerry Holton with the presentation of the AMA-ERF checks to Dr. I. Dodd Wilson, dean of the University of Arkansas College of Medicine. The first check for \$3,555.50 is intended for pursuit of excellence in the medical schools' program and is non-restricted. The second check for \$14,661.04 is restricted to the schools' program of financial assistance for medical students.

President Jones asked Dr. John Guenther of Mountain Home to come forward and be recognized for his 30 years of service on the Arkansas State Medical Board. Dr. Jones presented Dr. Guenther with a plaque of appreciation.

Dr. Jones also presented Dr. Joe Verser of Harrisburg with a plaque honoring him for his 43 years of leadership and devoted service to the Arkansas State Medical Board.

Speaker Crenshaw reminded the House that a second vote is required for the adoption of the revised AMS Constitution and Bylaws presented at the 114th annual meeting in May 1990. Hearing no opposition, the House voted unanimously to adopt the revised Constitution and Bylaws as printed in *The Journal of the Arkansas Medical Society*.

Speaker Crenshaw listed the items of business received by the society office at least 20 days prior to the meeting but after the printing of the convention issue of *The Journal*. Each item was assigned to a reference committee and was included in all packets. The items are as follows: Resolution from the Arkansas Ophthalmological Society concerning laser surgery; Resolution from the Washington County Medical Society concerning laser surgery; Resolution from the Boone County Medical Society regarding political involvement; and the Arkansas State Medical Board report.

Speaker Crenshaw announced the following vacancies on the state boards and reminded the congressional districts effected to meet following the adjournment of the House to select three nominees from which the governor will make appointments. The vacancies are: Sixth Congressional District, Arkansas State Medical Board; Third and Sixth District and Member-at-Large position, Arkansas State Board of Health.

Speaker Crenshaw announced the 1991-92 Nominating Committee as follows: District #1, Richard O. Martin, Paragould; District #2, Michael N. Moody, Salem; District #3, Samuel A. McGuire, Forrest City; District #4, Lee Forestiere, Pine Bluff; District #5, Cal Sanders, Camden; District #6, James D. Armstrong, Ashdown; District #7, Thomas Hollis, Hot Springs; District #8, Charles Logan, Little Rock; District #9, David Rogers, Fayetteville; and District #10, William Galloway, Russellville. He also reminded this committee to meet following the House of Delegates to elect their officers.

After announcements, the meeting was adjourned until Saturday, April 27th.



## Late Resolutions

### Resolution from the Washington County Medical Society Concerning Laser Surgery

Whereas, the Washington County Medical Society is concerned that the quality of care of patients undergoing laser surgery be safeguarded in the same tradition as patients undergoing other types of surgery; therefore be it

**Resolved**, the Washington County Medical Society strongly supports federal and state regulatory agencies' historic position that laser surgery should be performed by a licensed doctor of medicine or osteopathy and subject to established procedures of credentialing to assure training, proficiency, and safety; therefore be it

**Resolved**, that the Arkansas Medical Society formally adopt this position.

The officers and members of the Arkansas State Medical Board are W. Ray Jouett, M.D., chairman; Warren M. Douglas, M.D., vice chairman; Joe Verser, M.D., secretary/treasurer; Asa A. Crow, M.D.; Mr. John B. Currie Sr.; James L. Gardner, M.D.; Mr. Dewey Lantrip; Jim E. Lytle, M.D.; Linda Markland, M.D.; Alonzo D. Williams, M.D.; Rhys A. Williams, M.D.; George F. Wynne, M.D., and William H. Trice III, attorney.

The following is a summary of the Board's proceedings:

Physicians registered in 1990:

Resident - 3996

Nonresident - 2,828

Licensed by examination - 151

Licensed by National Board - 163

Licensed by Reciprocity - 192

Certified to other states - 282

Revoked non-payment registration fee - 168

Suspended non-payment registration fee - 129

Suspended violation Medical Practices Act - 8

### Arkansas State Medical Board

#### Balance Sheet as of June 30, 1990 and 1989

Current Assets	1990	1989
Cash	\$300,859	\$249,774
Certificates of deposit	533,207	435,749
Accrued interest receivable	8,245	7,731
Prepaid expenses	<u>793</u>	<u>336</u>
Total Current Assets	\$843,104	\$693,590

#### Property, Plant, & Equipment at Cost

Office equipment	\$35,805	\$34,055
Less accumul. deprec.	<u>22,399</u>	<u>16,853</u>
	13,406	17,202
	\$856,510	\$710,792

#### Liabilities and Fund Balance

Current Liabilities		
Accounts payable	\$47,830	\$55,420
Deferred income	<u>17,925</u>	<u>19,165</u>
Total Current Liabilities	65,755	74,585

Fund Balance	\$790,755	\$636,207
	\$856,510	\$710,792

### Resolution from the Boone County Medical Society Regarding Political Involvement

Whereas, the practice of medicine has been over regulated by both the state and federal government; and

Whereas, limited licensed practitioners have successfully used the legislature to extend their scope of practice beyond their training; and

Whereas, the U. S. Congress and the state legislature have been unwilling to address the many inequities in the tort system; and

Whereas, government policies and reimbursement rates have resulted in the closure of several rural hospitals and threatens the public's access to the health care system; and

Whereas, the Arkansas Medical Society has organized a Department of Governmental Affairs, under the direction of Mr. Lynn Zeno, to assist in influencing these external forces on the practice of medicine; and

Whereas, only through complete cooperation and participation of all physicians in the state will the powerful input of Arkansas' physicians be heard; therefore be it

**Resolved**, that the Arkansas Medical Society encourages each individual component medical society to form an active, on-going governmental affairs committee to develop a relationship and liaison with local and national legislators for the good of the people of Arkansas, our patients, and their constituents.

## Resolution from the Arkansas Ophthalmological Society Concerning Laser Surgery

Whereas, the expanding realm of medical technology requires the medical profession to be ever diligent in granting privileges to those will deliver and administer healing treatment to patients and maintain the highest standards of care; and

Whereas, lasers are surgical instruments that have been shown to be safe and effective when administered by a licensed physician; and

Whereas, the indiscriminate use of lasers may potentially harm if improperly used, and

Whereas, the American Academy of Ophthalmology has issued a policy statement regarding laser surgery; and

Whereas, the American College of Surgeons has accepted the resolution regarding laser surgery adopted by the AMA, and

Whereas, the American Academy of Pediatrics has accepted the resolution regarding laser surgery adopted by the AMA; and

Whereas, the Arkansas Ophthalmological Society has accepted the resolution regarding laser surgery adopted by the AMA; therefore be it

**Resolved**, that the Arkansas Medical Society adopt the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services.

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Dr. Gary Monroe  
7035 Hwy 6 South, Suite 175 A  
Houston, Texas 77083

## Final Session - April 27, 1991



Speaker Crenshaw called the meeting to order and asked Nominating Committee Chairman Charles Logan to present the revised Nominating Committee report. Dr. Logan read the following slate of officers:

#### President-elect:

J. Larry Lawson, M.D., Paragould  
Asa Crow, M.D., Paragould

#### First Vice President:

Michael N. Moody, M.D., Salem

#### Second Vice President:

Anna T. Ridling, M.D., Pine Bluff

#### Third Vice President:

William L. Rutledge, M.D., Little Rock

#### Treasurer:

James M. Kolb Jr., M.D., Russellville

#### Secretary:

Charles H. Rodgers, M.D., Little Rock

#### Speaker of the House:

John Crenshaw, M.D., Pine Bluff

#### Vice Speaker of the House:

Kelsy J. Caplinger III, M.D., Little Rock

#### Delegate to the AMA (1/1/92 - 12/31/93)

W. Payton Kolb, M.D., Little Rock

#### Alternate Delegate to the AMA (1/1/92 - 12/31/93):

Asa Crow, M.D., Paragould

#### Councilors:

##### District 1:

Merrill J. Osborne, M.D., Blytheville

##### District 2:

Jim E. Lytle, M.D., Batesville



District 3:

Hoy B. Speer Jr., M.D., Stuttgart

District 4:

Lloyd G. Langston, M.D., Pine Bluff

District 5:

Wayne G. Elliott, M.D., Camden

District 6:

F. E. Joyce, M.D., Texarkana

District 7:

Thomas H. Hollis, M.D., Hot Springs

District 8:

Glen F. Baker, M.D., Little Rock

Paul J. Cornell, M.D., Little Rock

Charles W. Logan, M.D., Little Rock

Robert F. Shannon, M.D., Little Rock

District 9:

David L. Rogers, M.D., Fayetteville

District 10:

Paul Wills, M.D., Fort Smith

Asa Crow asked to be recognized and have his name removed from the slate. J. Larry Lawson was elected president-elect by acclamation as were the other nominees.

Speaker Crenshaw asked President William Jones to come forward to address the delegates and members.

Following the speech, Ken LaMastus came to the podium to present Dr. Jones with a memento from the Society staff.

Speaker Crenshaw asked Payton Kolb to come to the podium to present AMA delegate plaques to T. E. Townsend and George Warren who are completing their terms as the Arkansas representatives to the American Medical Association House of Delegates.

The next order of business was the reports from the Reference Committees.

## Reference Committee #1



William Dedman, Camden, Chairman

William Galloway, Russellville

Hershel Garner, Fayetteville

John Troupe, Harrison

### Resolution from the Boone County Medical Society Regarding Political Involvement

Whereas, the practice of medicine has been over regulated by both the state and federal government; and

Whereas, limited licensed practitioners have successfully used the legislature to extend their scope of practice beyond their training; and

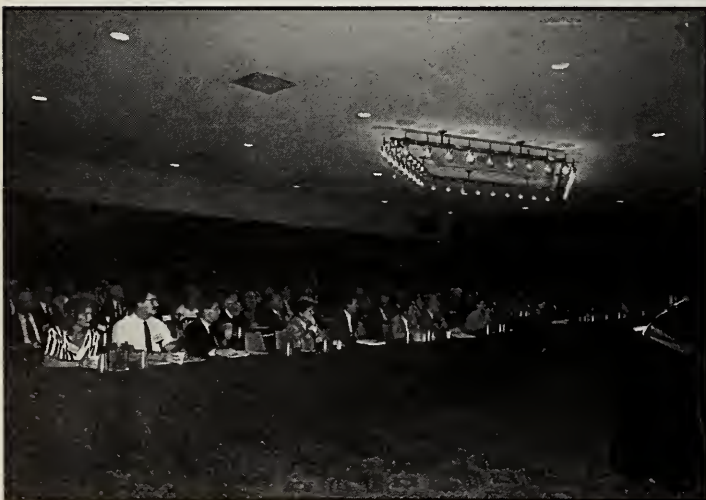
Whereas, the U. S. Congress and the state legislature have been unwilling to address the many inequities in the tort system; and

Whereas, government policies and reimbursement rates have resulted in the closure of several rural hospitals and threatens the public's access to the health care system; and

Whereas, the Arkansas Medical Society has organized a Department of Governmental Affairs, under the direction of Mr. Lynn Zeno, to assist in influencing these external forces on the practice of medicine; and

Whereas, only through complete cooperation and participation of all physicians in the state will the powerful input of Arkansas' physicians be heard; therefore be it

**Resolved**, that the Arkansas Medical Society encourages each individual component medical society to form an active, on-going governmental affairs committee to develop a relationship and liaison with local and national legislators



for the good of the people of Arkansas, our patients, and their constituents.

*Reference Committee #1 recommends that this resolution be adopted.*

HOUSE ACTION: **ADOPTED AS WRITTEN**

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**Amendment to the Bylaws: "Council Chairman  
(Chapter V, Section 6[A])"**

"Add to current language...This limit shall not apply to the councilor who (1) is serving as chairman, and (2) is otherwise eligible to be re-elected chairman; provided no member shall serve as chairman more than six consecutive years."

*Reference Committee #1 recommends that this amendment be adopted.*

HOUSE ACTION: **ADOPTED AS WRITTEN**

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**Amendment to the Bylaws: "AMA Delegates  
(Chapter V, Section 6[B])"**

"Delegates and alternate delegates to the American Medical Association shall be elected in accordance with the Bylaws of that organization; provided no member shall serve for more than a combined total of 12 consecutive years. This limit shall not apply to any delegate or alternate delegate while serving in an elected or appointed position on an AMA council, committee, or board."

*Reference Committee #1 recommends that this amendment be adopted.*

HOUSE ACTION: **ADOPTED AS WRITTEN**

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**University of Arkansas for Medical Sciences Report  
I. Dodd Wilson, M.D., Dean**

Reference Committee #1 recommends that this report be **filed for information** and that the dean investigate the issue of equitable treatment for residents who were called to service for Desert Storm regarding residency credit for their active duty service and that the dean report the results to the Council.

HOUSE ACTION: **FILED FOR INFORMATION**

**Arkansas State Medical Board Report  
Joe Verser, M.D., Secretary**

Reference Committee #1 commends Dr. Verser for his 43 years of faithful service to the citizens of Arkansas and the medical profession and recommends that this report be **filed for information**.

HOUSE ACTION: **FILED FOR INFORMATION**

---

**Report of the Governmental Affairs Council  
Charles Rodgers, M.D., Chairman**

Reference Committee #1 discussed that currently only 5% of the Arkansas Medical Society members are supporting MED-PAC. Despite this meager support, this reference committee commends the outstanding successes achieved during the recent legislative session, with our major victories more than doubling our losses. Furthermore, this reference committee commends Drs. Charles Rodgers, Jim Weber, Payton Kolb, Bill Jones, Michael Moody, and all the other physicians and auxiliary members who served on our legislative team. This reference committee especially recognizes Mr. Zeno, Mr. Mitchell, and the entire AMS staff, not only for their work during the session, but also for their continuing efforts in assisting the organization of governmental affairs units in our local county medical societies and auxiliaries.

*Reference Committee #1 recommends that this report be filed for information.*

HOUSE ACTION: **FILED FOR INFORMATION**

---

Reference Committee #1 recommends that the following reports printed in the March issue of *The Journal of the Arkansas Medical Society* be **filed for information**:

**Report of the Council, Larry Lawson, M.D., Chairman  
Fifth Councilor District, Wayne G. Elliott, M.D., Councilor  
Eighth Councilor District and Pulaski County Medical Society,  
Charles Logan, M.D., Councilor and J. Mayne Parker, M.D.,  
President**

**Tenth Councilor District, Morton C. Wilson, M.D., Councilor  
Report of the Executive Vice President, Ken LaMastus, Execu-  
tive Vice President**

**Pension Plan Trustees, J. Floyd Kyser, M.D., Chairman**

**Report of the Constitutional Revision Task Force, Warren  
Douglas, M.D., Chairman**

**Medical Education Foundation for Arkansas (MEFFA), Martin  
Eisele, M.D., President**

HOUSE ACTION: **FILED FOR INFORMATION**



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## Reference Committee #2

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John Lange, Fort Smith, Chairman  
Stephen Goss, Bentonville  
Anna Ridling, Pine Bluff

Reference Committee #2 considered the following resolutions from the Arkansas Ophthalmological Society and the Washington County Medical Society jointly because both resolutions address the same issue.

### Resolution from the Arkansas Ophthalmological Society Concerning Laser Surgery

Whereas, the expanding realm of medical technology requires the medical profession to be ever diligent in granting privileges to those will deliver and administer healing treatment to patients and maintain the highest standards of care; and

Whereas, lasers are surgical instruments that have been shown to be safe and effective when administered by a licensed physician; and

Whereas, the indiscriminate use of lasers may potentially harm if improperly used, and

Whereas, the American Academy of Ophthalmology has issued a policy statement regarding laser surgery; and

Whereas, the American College of Surgeons has accepted the resolution regarding laser surgery adopted by the AMA, and

Whereas, the American Academy of Pediatrics has accepted the resolution regarding laser surgery adopted by the AMA; and

Whereas, the Arkansas Ophthalmological Society has accepted the resolution regarding laser surgery adopted by the AMA; therefore be it

**Resolved**, that the Arkansas Medical Society adopt the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services.

### Resolution from the Washington County Medical Society Concerning Laser Surgery

Whereas, the Washington County Medical Society is concerned that the quality of care of patients undergoing laser surgery be safeguarded in the same tradition as patients undergoing other types of surgery; therefore be it

**Resolved**, the Washington County Medical Society strongly supports federal and state regulatory agencies' historic position that laser surgery should be performed by a licensed doctor of medicine or osteopathy and subject to established procedures of credentialing to assure training, proficiency, and safety; therefore be it

**Resolved**, that the Arkansas Medical Society formally adopt this position.

**COMMENTS:** The risk and morbidity of laser surgery in the field of ophthalmology was discussed. Concerns were raised about the safe use of the laser in all medical specialties. Discussion focused on licensure through the Arkansas State Medical Board and potential legislation.

Reference Committee #2 recommends that the two resolutions be combined and that the following combined resolve be adopted:

**Resolved**, that the Arkansas Medical Society adopt the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services.

**HOUSE ACTION: ADOPTED AS RECOMMENDED**

---

Reference Committee #2 gave careful consideration to the following items and requested that they be considered separately:

**AIDS Committee Report**  
Joseph Beck II, M.D., Chairman

The committee was instrumental in the passage of Act 575 requiring plasma centers to notify donors of HIV-positive test. The HIV Shield Law was passed allowing physicians to draw an HIV test when medically indicated without the patients consent. The committee has a report prepared regarding health care disability insurance issues for health care workers as requested by the Young Physicians Committee.

Reference Committee #2 recommends that the AIDS Committee report be **filed for information**.

**HOUSE ACTION: FILED FOR INFORMATION**

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**Annual Session Report**  
Glen F. Baker, M.D., Chairman

Reference Committee #2 recommends that the Annual Session Report be **filed for information** and that Dr. Glen Baker be commended for his outstanding leadership over several years as chairman of this committee. We commended Peggy Cryer and the Arkansas Medical Society staff for their assistance.

**HOUSE ACTION: FILED FOR INFORMATION**

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**Arkansas Health Care Access Foundation Report**  
W. Ray Jouett, M.D., Chairman

Dr. James Weber stated that physician usage of lab, x-ray, and pharmaceutical samples has been tracked in this program. This information has been used as a model to report physician behavior before national forums.

Reference Committee #2 recommends that the Arkansas Health Care Access Foundation report be **filed for information**.

**HOUSE ACTION: FILED FOR INFORMATION**

Reference Committee #2 recommends that the following reports printed in the March issue of *The Journal of the Arkansas Medical Society* be **filed for information**:

Budget Committee, James Armstrong, M.D., Chairman  
Medical Services Review Committee, John Crenshaw, M.D., Chairman  
Task Force on Perinatal Care Access, William Dedman, M.D., Chairman  
Physicians' Health Committee, Joe L. Martindale, M.D., Chairman  
CrittendenJ County Medical Society, Steve Schoettle, M.D., Chairman  
Sebastian County Medical Society, Taylor Prewitt, M.D., Chairman  
Tri-County Medical Society, Lewis G. Allen, M.D., Chairman

**HOUSE ACTION: FILED FOR INFORMATION**

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Speaker Crenshaw asked the Chairman of the Council, J. Larry Lawson, to give the report of the Council which met daily during the meeting.

## **COLORADO**

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## Report of the Council

J. Larry Lawson, M.D., Chairman

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The Council met on Thursday, April 25, at the Arlington Hotel in Hot Springs. The following business was received and transacted.

1. Approved the minutes of the March 3, 1991 Council meeting.
2. Approved the minutes of the March 27, 1991 Executive Committee meeting.
3. Dr. John Clowe, Speaker of the AMA House of Delegates, addressed the Council.
4. Reviewed the membership report of the period ending March 30, 1991.
5. Dr. Glen Baker reported on the study of the Mississippi State Medical Society self-insured insurance program.
6. Dr. Charles Rodgers gave a legislative update on the recent legislative session. Other reports were presented by Dr. Michael Moody, Mike Mitchell, Lynn Zeno, and Dr. William Jones.
7. Approved the life, emeritus, affiliate, and military memberships as presented.

The Council met on Friday, April 26th. The following business was received and transacted:

1. Dr. Morton Wilson reminded the Council of the Arkansas Foundation for Medical Care meeting Sunday morning at the Majestic Hotel.

2. Dr. Merrill Osborne reviewed the 1990 AMS audit prepared by Ferguson, Cobb, and Associates.
3. The Budget Committee recommended the following:
  - a. \$1,000 be given to the Arkansas Research Center
  - b. the budget for the president's travel be raised from \$4,000 to \$6,000
  - c. Suggested that the Arkansas Medical Society Auxiliary increase their yearly membership dues although the Arkansas Medical Society will continue to assist them with their projects and programs.
4. Voted to open an account with Merrill Lynch that would allow for insurance coverage on amounts over \$100,000. These higher interest accounts would benefit the society through increased interest income.
5. The following Council committee appointments were approved:
  - a. Medical Services Review Committee  
Anesthesiology: Howell Hill, Benton  
Family practice: Harold Wilson, Monticello and Joe H. Stallings, Jonesboro  
General surgery: Patrick N. Osam, Little Rock  
Internal medicine: Lee Abel, Little Rock  
Neurosurgery: W. Ray Jouett, Little Rock (interim until a permanent representative is located)  
Psychiatry: Max A. Baker, Fort Smith  
Urology: Robert Bell, Russellville
  - b. Medical Services Review Committee Subspecialties:  
Emergency medicine: William G. McDonald, Little Rock  
Gastroenterology: Thomas J. Smith, Little Rock  
Nephrology: James A. Wellons, Little Rock  
Oral surgery: Robert Anderson, Little Rock  
Pediatric allergy: Joseph W. Matthews, Little Rock  
Plastic surgery: Luther Walley, Hot Springs  
Pulmonary disorders: John C. Schultz, Little Rock  
Thoracic surgery: Leon P. Woods, Fort Smith  
Cardiovascular surgery: position will be filled at a later date
  - c. Pension Plan Trustees: James Pappas, Little Rock
  - d. Medical Education Foundation for Arkansas: Gerald Stolz, Russellville
  - e. Committee on Position Papers: Lloyd Langston, Pine Bluff  
Paul Cornell, Little Rock  
David Barclay, Little Rock
  - f. Budget Committee: Wayne Elliott of El Dorado will fill the unexpired term of Warren Douglas. Thomas Hollis of Hot Springs was elected to serve a three-year term beginning January 1, 1992.
  - g. Young Physicians' Committee:  
District #2: Griffin Arnold, Little Rock  
District #4: Anna Ridling, Pine Bluff  
District #5: Gary Bevill, El Dorado  
District #6: Jonathan Hoyt, DeQueen

There being no further business the Council adjourned.

Speaker Crenshaw announced the following State Board nominees:

Sixth Congressional District, Arkansas State Medical Board: Don Howard, Fordyce; David Jacks, Pine Bluff; and Harold Wilson, Monticello.

Third Congressional District, Arkansas State Board of Health: Ken Lilly, Fort Smith; A. C. Bradford, Fort Smith; and Morton Wilson, Fort Smith.

Sixth Congressional District, Arkansas State Board of Health: Howard Harris, Dumas; John Hestir, DeWitt; and Lloyd Langston, Pine Bluff.

Member-at-Large, Arkansas State Board of Health: Robert Miller, Helena; Charles Logan, Little Rock; and David Rogers, Fayetteville.

Speaker Crenshaw announced the 1991-92 Nominating Committee officers: Charles Logan, Little Rock, Chairman; and David Rogers, Fayetteville, Secretary.

Speaker Crenshaw recognized Morton Wilson who encouraged everyone to attend the Arkansas Foundation for Medical Care meeting Sunday, April 28th at the Majestic Hotel.

There being no further business, the meeting was adjourned.

## Full Steam Ahead

The totals are in...we were a success again this year!

115th Annual Session  
of the Arkansas Medical Society  
Arlington Hotel, Hot Springs  
April 25 - 27, 1991

Physicians	329
Spouses	122
Dentists, Nurses & Students	61
Exhibitors	<u>170</u>
<b>Total attendance</b>	<b>682</b>

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## **1991-1992 OFFICERS**

George Warren, Smackover, President  
J. Larry Lawson, President-elect  
Michael N. Moody, Salem, First Vice President  
Anna T. Ridling, Pine Bluff, Second Vice President  
William L. Rutledge, Little Rock, Third Vice President  
Charles Rodgers, Little Rock, Secretary  
James M. Kolb Jr., Treasurer, Russellville  
John Crenshaw, Pine Bluff, Speaker of the House  
Kelsy J. Caplinger III, Little Rock, Vice Speaker, House of Delegates

## **EXECUTIVE COMMITTEE**

Charles Logan, Little Rock, Chairman of the Council  
George Warren, Smackover, President  
J. Larry Lawson, President-elect  
Charles Rodgers, Little Rock, Secretary  
James M. Kolb Jr., Russellville, Treasurer  
William N. Jones, Little Rock, Immediate Past President

## **COUNCILORS AND COUNCILOR DISTRICTS**

### **FIRST DISTRICT**

Dwight Williams, Paragould (1992); Merrill Osborne, Blytheville (1993); Clay, Craighead, Crittenden, Greene, Lawrence, Mississippi, Poinsett, Randolph Counties

### **SECOND DISTRICT**

John Bell, Searcy (1992); Jim Lytle, Batesville (1993); Cleburne, Conway, Faulkner, Fulton, Independence, Izard, Jackson, Sharp, Stone, and White Counties

### **THIRD DISTRICT**

L. J. P. Bell, Helena (1992); Hoy Speer, Stuttgart (1993); Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis, and Woodruff Counties

### **FOURTH DISTRICT**

Paul Wallick, Monticello (1992); Lloyd Langston, Pine Bluff (1993); Ashley, Chicot, Desha, Drew, Jefferson, and Lincoln Counties,

### **FIFTH DISTRICT**

Cal Sanders, Camden, (1992); Wayne Elliott, El Dorado (1993); Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita, and Union

### **SIXTH DISTRICT**

James Armstrong, Ashdown (1992); F. E. Joyce, Texarkana (1993); Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Pike, Polk, and Sevier Counties

### **SEVENTH DISTRICT**

Ronald Bracken, Hot Springs (1992); Thomas Hollis, Hot Springs (1993); Clark, Garland, Grant, Hot Spring, Montgomery, and Saline Counties

### **EIGHTH DISTRICT**

David Barclay, Little Rock (1992); Glen Baker, Little Rock (1993); R. Jerry Mann, Little Rock (1992); Harold Purdy, Little Rock (1992); Paul Cornell, Little Rock (1993); Charles Logan, Little Rock (1993); Robert Shannon, Little Rock (1993); Pulaski County

### **NINTH DISTRICT**

Robert Langston, Harrison (1992); David Rogers, Fayetteville (1993); Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren, and Washington Counties

### **TENTH DISTRICT**

Morton C. Wilson, Fort Smith (1992); Gerald Stolz, Russellville (1993); Paul Wills, Fort Smith (1993); Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian, and Yell Counties



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# 1991 AMS



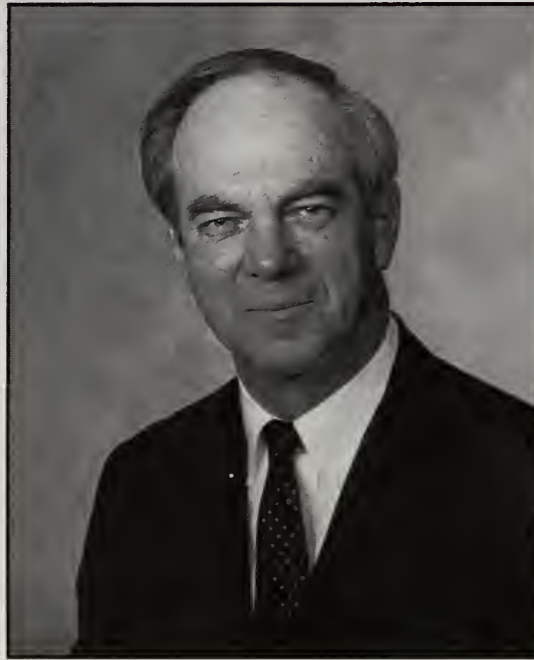


# Annual Session





Address by William N. Jones, M.D.  
1990-91 President



Governor Clinton, Dr. Clowe, Dr. Crenshaw, members of the Society and guests:

When I first read the agenda for the last session of the House of Delegate of this 115th Annual Session of the Arkansas Medical Society, I became a little distressed by my part on the program. First of all, it calls this a "Farewell Address" and I am not saying goodbye or SEE YOU LATER ALLIGATOR and second it refers to me as past president and I am still president until George Warren takes the oath of office this evening!

A few weeks ago, I nearly caused George to have a heart attack. I told him I was having so much fun I was considering running for president again. After all, I didn't get to serve a whole year since I took office in May. My advice to the Nominating Committee is never put my name in as the token president-elect nominee because I will make it a serious contest. I have arrived at the solution to my problem. I will prepare an amendment to the Constitution and Bylaws - the Papa Doc Amendment - and I will be president for life!

In all sincerity, I can truly say the last two years have been the most exciting and personally gratifying of all the 14 I have served this Society. As your president, it has been my great honor and privilege to represent you in Arkansas and at the national level both in Washington and at meetings of the House of Delegates of the American Medical Association. I have enjoyed every minute of the experience. I deeply

appreciate the respect and esteem of you my colleagues. I know that together we have made a difference.

I call your attention to my inaugural address and all of the very positive things I mentioned about the state of the Arkansas Medical Society as we entered the 1990's. This year we witnessed reinforcement of all the strengths of this Society. The strong leadership of the Executive Committee, the Council, the House of Delegates, and particularly our involvement and rapport with the officers and staff of the American Medical Association has been very satisfying.

I have sought and will continue to encourage the participation of the young physicians in our Society. I am pleased with their responsiveness and I hope their involvement will increase in the years to come. The Society needs their vision and energy and we must tap this resource before they find other avenues of commitment and service.

Many of the accomplishments of the past year are listed and discussed in the Council and Committee reports published in the March issue of *The Journal of the Arkansas Medical Society*.

Last May, I set goals for our immediate future all of which have been addressed. We have now received and accepted the revisions in our Constitution and Bylaws as proposed by a task force headed by Warren Douglas and with the invaluable assistance of David Wroten.

Our Smoking and Tobacco Products Committee, chaired



by David Rogers, led the fight that resulted in the passage of the Tobacco Free Youth Bill, Act 543 of 1991. This committee has formed a coalition and begun the legislative process to prohibit smoking in public places. In addition, they have successfully conducted the National Institutes of Health seminar entitled, "How to Help Your Patient Stop Smoking."

Under the leadership of Marvin Leibovich, we have started our partnership with the Arkansas Bar Association against drug and alcohol abuse in our youth.

I am also pleased to report that Ken LaMastus has begun a serious effort to stop smoking, although he still needs our support and encouragement.

The Committee on AIDS, chaired by Joe Beck, has continued to do impressive work. Their educational commitment to our Society and to the people of Arkansas is exemplary. We have just benefited from the 4th Annual Seminar on HIV disease. The writing and ultimate passage of Act 575 requiring testing and reporting of HIV seropositivity by

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"So I say to the Arkansas Medical Society and our new president, George Warren, 'The best is yet to come!'"

---

blood and plasma centers, Act 289 - the HIV Shield Law and House Concurrent Resolution 1011 expressing opposition to immigration of HIV infected persons, were the direct result of the involvement of AIDS committee members.

During the past year, we have witnessed and endorsed major changes in the location, operation, and structure of the Arkansas State Medical Board. Our Physicians' Health Committee, directed by Joe Martindale, has been strengthened and continues to do great service.

The Arkansas Medical Society Auxiliary successfully completed the DWI Teenage Project started by Sara Jouett and Nikki Lawson and finished by Jo Ann Williams. Rita Rodgers and Jo Ann have begun another major undertaking with preliminary work on a statewide health conference for adolescents and teens.

A delegation from our Society met with HCFA officials in Washington to discuss the negative impact on access to care and interference with timely diagnosis and treatment that would result from the implementation of CLIA '88. Society members made several other trips to Washington to visit our congressional delegation.

During the year our Society successfully appealed a decision by the Workers' Compensation Commission that would have required the physician to be partially responsible for the legal fees of the patient. We also intervened and

placed a hold on major refunds of Medicaid payments.

A special committee, assisted by David Wroten, has developed a fee system acceptable to physicians and the Workers' Compensation Commission.

The Arkansas Health Care Access Foundation has completed its first year and is helping fill a void in health care for our noninsured citizens.

Congress and the administration in Washington appeared to give the War in the Persian Gulf most of their attention during the last nine months. However, with the new session of Congress we can look forward to several medical initiatives. Stark and Kennedy will be back with their agenda including recertification, triplicate prescriptions, and reduction in profit margins. We will also have further concerns with RBRVS, Data Bank, and access to care. The American Medical Association will be supporting additional anti-hassle legislation, tort reform, and seeking support for Health Access America, a program endorsed by the Arkansas Medical Society.

We have just completed a very successful legislative effort in the General Assembly. Our campaign was led from the beginning to the bitter end by lobbyists Lynn Zeno and Mike Mitchell. Their expertise and knowledge of the legislative process and their relationship and rapport with the Governor, his staff, and members of the legislature are the envy of their peers. They have done an outstanding job and deserve special recognition by the House of Delegates.



Many of you participated in the "Doctor of the Day" program. Some members of the Society and the auxiliary lobbied in person and some by telephone and the mail. The Governmental Affairs Council and its chairman, Charles Rodgers, are to be commended for their work. A few of the highlights not already mentioned include the passage of our bill to reduce the statute of limitations for obstetrical care, passage of the Medicaid provider excise tax, passage of mandatory wearing of seat belts, and passage of bills to attract physicians to rural areas of Arkansas. Members of the



Society were involved in defeat of a bill that would allow nurse practitioners to prescribe medications. We also influenced the defeat of the Smoker's Rights Bill, and a bill to repeal the motorcycle helmet law.

It is difficult to express my appreciation of Lynn Zeno and his effectiveness and devotion to the political success of this Society. When he walks into the Capitol, his face lights up like a little boy on Christmas morning. I must tell you however, not everyone in the Society feels this way about Lynn. He was particularly humbled by one of our members recently. Lynn had just introduced himself and the member asked what he did for the Society. The conversation continued, "I am the Society's lobbyist." The member responded, "Why do we need a lobbyist?" After Lynn had apparently satisfied the member's doubt, our now well-informed colleague replied, "It must be tough on you driving down from Ft. Smith every day!" There are many messages in this true story!

At my request, Glen Baker has served as chairman of the Annual Session Committee again this year. We all appreciate his work but he would be the first to give all the credit to Peggy Cryer and her staff who have worked tirelessly to insure another fantastic meeting. Every year the program seems to be better than the last! Let's give them all a round of applause.



I have felt one strong emotion this year - excitement! It has been an unbelievably fun trip and a joy to have worked with such supportive people on so many different issues and seen so much accomplished. I want to thank everyone who has been a part of it, but first and foremost, Ruthie, who, as she has throughout our marriage, given me her total support and encouragement.

Ken LaMastus and his staff have continued to smile in spite of my four to six telephone calls a day and the numerous requests for letter typing. On several occasions I presented them with a letter and enclosures that by noon they had

mailed to the other 49 state medical society presidents, the officers and staff of the AMA, and our congressional delegation. You can all be very proud of their good stewardship and their work and devotion to the Arkansas Medical Society. I would like for Ken and his staff to stand and receive our applause.

I recently heard an explanation of the difference between an optimist and a pessimist. If it should ultimately prove that the pessimist was correct, at least the optimist had the most fun along the way. Some persons subscribe to the

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"We must become even more politically oriented and organized if we are to continually defeat the forces that would destroy medicine as we know it."

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philosophy expressed by, "Life is uncertain so eat dessert first!" But I like the optimism reflected in, "The best is yet to come!" So I say to the Arkansas Medical Society and our new president, George Warren, "The best is yet to come!"

The 78th General Assembly of Arkansas is now history. The Arkansas Medical Society had great success during the legislative session. However, as we observe and consider what is currently proposed in the legislatures of the states of Florida, Pennsylvania, and Ohio, we can guess what is in store for Arkansas. We must become even more politically oriented and organized if we are to continually defeat the forces that would destroy medicine as we know it. Now more than ever, we must individually commit our time and money to the political process. To do otherwise will result in the further erosion of our ability to care for our patients. I challenge each of you to become MED-PAC members now!

It is as true today as it was when I first stated it months ago and it bears repeating....All of us who have taken on the responsibility of leadership from time to time have been critical about some aspect of the AMA and the AMS. It behooves us to change what we perceive as wrong or poor policy because, like it or not, Congress and our state legislature look to those bodies for advice and direction in matters that concern the public health and how medicine is, and will be, practiced.

In closing, I again want to thank you for the honor and privilege of serving you as president. I promised you, on my honor, I would do my best and I am proud to say I have fulfilled that promise.

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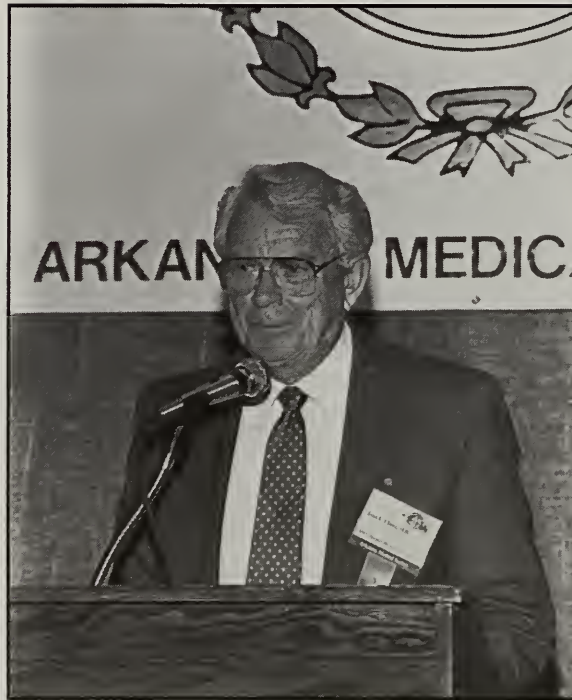
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## Address by John Clowe, M.D.

Speaker, House of Delegates  
American Medical Association



Good afternoon. I am pleased to be here to update you on what the American Medical Association is doing for each and every doctor and each and every patient in Arkansas.

When I heard that your conference theme is FULL STEAM AHEAD, I recalled the story about a trial run of the first American steamboat — Robert Fulton's "Clermont."

This Hudson River demonstration drew a big crowd, including a pessimistic old codger who predicted loud and clear "They'll never start her!" But the steamboat did start. Its speed increased. And as it went faster and faster, belching black billows of smoke from its funnel, the crowds along the river went wild!

How did the old codger respond to this success? He just turned away, shaking his head in disbelief. And he sighed, "But they'll never stop her!"

Well, that just goes to prove the world will always have its pessimists! But we will always have optimists, too. Optimists like Robert Fulton, who knew what it meant to say: FULL STEAM AHEAD! Optimists like all of you — who have the dedication and the concern and the optimism to get involved in this House of Delegates and commit yourselves to going FULL STEAM AHEAD. Optimists like the American Medical Association, which is a confederation of doctors who care enough about medicine to handle those necessary activities that we can't handle individually.

There are lots of examples of what the American Medical Association has done for every doctor in Arkansas, AMA

member or not — and, by extension, these are things we do to assure that all Arkansas physicians are able to give the very best care and service to all of your patients.

We publish The Journal of the American Medical Association and all of the other specialty journals — including new JAMA editions in Russian and Polish! We issue scientific papers and ethical guidelines. We and oversee accreditation of medical education programs for all physicians — AMA member or not.

All these activities benefit the entire family of medicine — not just those who join the American Medical Association. It is all part of serving the profession, so that individual physicians are able to go full steam ahead in serving our patients.

Another way we help all Arkansas physicians is by representing you in legislative and judicial activities where you need a national presence to stand up for you in Washington. So I'd like to review some recent cases where the AMA has accomplished important results for individual American physicians, for our profession, and — most of all — for the patients we all serve.

Let's start with some legislative accomplishments we have achieved because we went full steam ahead and presented a unified front for medicine. Just look at the landmark legislation against some of the "hassle factors" that have been making it difficult for us physicians to provide our patients with the medical service they deserve and need.



With the AMA dogging legislators all the way, and with the enlightened leadership of Senator Max Baucus and Representative Roy Rowland, who is a physician, we started the process of eliminating "hassle factors" in four areas.

First, doctors can now bill for up to 60 days of services provided to a Medicare patient under a cross-coverage agreement. This means if Doctor Smith takes care of my Medicare patient this weekend and I take care of Doctor Smith's Medicare patient next weekend, we don't have to cross-bill. We can bill our own patients without the government calling it fraud!

Second, we won the creation of a 15-member Practicing Physicians Advisory Council that will meet with Medicare officials every three months to discuss proposed changes in regulations and carrier instructions. I want to stress that this council will be made up of PRACTICING physicians — doctors who know what it means to treat a patient and deal with the Medicare system. It will include both participating and non-participating physicians and both rural and urban physicians.

Third, the legislation also requires the Department of Health and Human Services to conduct a demonstration in which carriers will publish the trigger points for their utilization review screens. This demonstration project was originally slated for six states, but now it will survey thirteen states, instead. And it mandates an additional study of the impact of allowing physicians to aggregate claims denials involving common issues and to make joint appeals to reverse denials and unfair carrier practices.

Fourth, we beat back a requirement that certain physicians get permission from unqualified Medicare carriers before proceeding with many services and a proposed "user fee" that would have cost physicians one dollar every time they filed a paper claim. In fact, if you see just eight Medicare patients every week, we've saved your American Medical Association dues for you in 1991 — just by beating this dollar filing fee!

And we've done a lot more for you and your patients!

We've fought off Congressman Stark's proposal to require periodic recertification of physicians. And we've made a big impact with our response to changes proposed by the Clinical Laboratory Improvement Amendments — or CLIA. Working together as a Federation, the family of medicine generated a torrent of mail to the Health Care Financing Administration — more than 60,000 letters. As a result, we convinced HCFA both to extend the original comment period last fall and also to recognize the need for major changes in the proposed regulation.

Then there is the matter of the Inspector General. When Health and Human Services Inspector General Richard Kusserow instituted policies that would pay his key enforcers a "bounty" to increase the number of physician sanctions they brought in the American Medical Association protested to him on behalf of all of America's physicians.

Last fall, on the television program "Primetime Live"

correspondent Chris Wallace interviewed a New York physician who was threatened with expulsion from Medicare or Medicaid because Kusserow's Medicaid auditors reviewed a small sample of his cases and decided four tests he'd ordered were unnecessary. Wallace also interviewed the widow of a country doctor described as an old-fashioned practitioner who still made house calls. Kusserow's office had taken him out of the Medicaid program. In a televised interview, the Inspector General accused the doctor of drug abuse, but on further questioning, Kusserow had to retract that.

After that "Primetime Live" episode aired, the American Medical Association called for Kusserow's resignation, and so did leaders of nearly all the state medical societies all across the land. Only President Bush can remove Kusserow, and though this has not happened, our action has already gotten some good results from our campaign.

The courts agreed that it was a "bounty system" and must stop. The Inspector General did not get the expansion of authority that he requested from the last Congress. He has abandoned the kind of reckless and unfounded statements we heard from him in the past.

Now I understand that here in Arkansas, you are in the unique position of having Medicaid reimbursements that are higher than Medicare, and that you have won a recent Medicaid reimbursement increase of 20 percent! That is commendable. And it is in large part a testament to this Society's good relationship with your legislature.

But I know you have very low Medicare rates here, so I imagine that Medicare budget cuts are a topic of great concern to you. The Bush administration had originally proposed cuts of \$5.5 billion dollars in Medicare for the 1991 fiscal year. But the American Medical Association was able to minimize what could have been disastrous cuts in Medicare reimbursement this year. The final legislation reduced that figure to \$3.3 billion. Given the federal government's budget-driven approach to Medicare, that is a very big victory indeed.

I would like to turn now to the resource-based relative value scale — or RBRVS — for Medicare physician payments. As you may know, further changes are likely before a final schedule is published next fall, and in addition, refinements are likely to continue throughout the transition.

The RBRVS Notice of Proposed Rule Making, which was supposed to be out the first of this month for public comment, has been delayed a few weeks. Yet even so, we are relatively certain that we know how the relative scale will shape up for the work and costs components of Medicare physician payment.

There may well be some unhappiness over accuracies of the geographic practice cost indices — which are charmingly known as GPCIs (pronounced GYPSIES). If Congress adopts the current geographic adjustment factors recommended by the Health Care Financing Administration and the Physician Payment Review Commission, it will be compressing the geographic variation down from as much as several hundred percent to a maximum of twenty-nine per-



cent. That corrects the geographic factor in reimbursement, and it should help rural doctors immensely.

Our chief concern about RBRVS at this point is a monetary multiplier that will convert the Harvard study's relative values to actual Medicare dollars. Congress ordered HCFA to set a conversion factor so that overall spending on medical services in 1992 is the same as if there had been no RBRVS. But to do this, HCFA must predict the number and type of services, as well as payment levels.

Payment changes will for the most part be dictated by the Harvard work and by HCFA implementation of Congressionally-directed practice cost and professional liability relative values. But the volume and distribution of services is less certain. That is because Medicare actuaries have always argued that to save one dollar, Congress must cut physician fees by two dollars because they predict doctors will boost services enough to recoup half their losses.

This is called the behavioral assumption — or the behavioral offset. There is no valid data to support it, and the American Medical Association has consistently opposed it. We believe that this assumption underestimates physicians' integrity and also our patients' intelligence and assertiveness. Further, applying a behavioral assumption would lower the conversion factor and reduce payments for all services.

On another matter related to RBRVS — though I understand that Arkansas has among the lowest malpractice insurance rates in the nation, you will understand why another thing we have been concerned about is to be sure that malpractice costs are incorporated into the payment schedule so that physicians will be paid for them in a fair and equitable manner.

Throughout the payment reform process, the American Medical Association has been a clearinghouse on payment reform for the Federation, and we will continue this role. The AMA's CPT Editorial Panel has taken the lead in revising CPT codes for visits and consultations to improve their appropriateness for use in an RBRVS system. And as we get closer and closer to implementing the RBRVS, the American Medical Association's health policy group is keeping the family of medicine current on all RBRVS issues by publishing a regular newsletter called the Physician Payment Update.

And by scheduling various meetings and briefings to communicate RBRVS issues to medical society staff and officers from all around the country — and to get your input, as well, for our ongoing work with PPRC. Now that I have summarized all these activities, the American Medical Association has undertaken for you and your patients concerning not just physician payment reform, but the many national issues where you need representation.

I want to conclude by telling you how we are leading the family of medicine in the complicated task of providing access to care for all Americans. For quite some time now, it has been clear that if America's physicians want to see access moved higher on the national agenda, we are going to

have to be the ones to move it there.

And I can report with pride and optimism that we're moving full steam ahead on this. In fact, AFL-CIO president Lane Kirkland recently told an American Medical Association meeting that many responsible employers and employees are tired of bearing heavy cost-shifting burdens for the uninsured — tired of subsidizing those who cannot or will not pull their own weight. He said the cost issue has moved the health care crisis past the fringes of society to the hard-working middle class.

Senator Jay Rockefeller, who chaired the Bi-Partisan Pepper Commission told that same gathering: "There's a drumbeat for cost containment that's growing and it's no longer coming just from the bean counters in Washington. "It's coming from employers and unions and governors and families."

So, you see, it is no longer a question of IF the health care system is going to change, but of HOW it will change. And, that "how" depends largely on what the catalysts for change will be. A U.S. senator said recently that until people are dying in the streets for lack of medical treatment, Congress will not act on U.S. health care reform. He meant, of course, that it takes an immediate, burning issue before Congress will respond with legislation.

If America waits for public sentiment to explode, we may get radical change that would destroy all that is good about the current health care system that serves a vast majority of Americans very well. But if we act NOW to build solid public interest for a more reasoned, thorough national approach, we can achieve positive reform and avoid disruptive change.

In fact, many of America's most dedicated and concerned leaders are already hard at work to ensure thoughtful health care system reform. They are following the time-honored American pattern of debate consideration and compromise. And largely as a result of medicine's role in this process, once-opposing factions are now beginning to join together for workable reform.

Most decision-makers now understand that it would be a terrible mistake to start a new nationalized health insurance system from scratch or to import a foreign system such as the Canadian system. The Center for Health Policy Research declared that to fund this, our payroll tax would go from 15 to 29 percent, the income tax would go from 33 to 47 percent, or if it were funded by consumptive tax, the cost of everything you bought would increase 10 percent.

Senator Kennedy and others who once supported nationalized medicine have moved away from that concept. They are looking carefully at our Health Access America proposal. Senator Rockefeller calls Health Access America "virtually interchangeable" with the Pepper Commission's recommended package. Both plans would bring costs under control through reforms in professional liability insurance "practice parameter" guidelines for appropriate, cost-effective care, encouraging health promotion and disease prevention, rewarding people for making economical health care insurance choices and



repealing expensive state-mandated benefit laws. Both proposals ask business to insure the 24 million employed, but uninsured, Americans. Both include tax incentives provisions to keep a lid on expenses and state risk pooling to reduce the financial strain of providing health insurance for all employees.

Health Access America also would extend Medicaid to cover all of the poor it was originally intended to serve — rather than the present 40 percent. We would transform Medicare from a program flirting with bankruptcy to one that is prefunded and actuarially sound.

With the Health Access America proposal, the American Medical Association has given medicine a seat at the table where the deals will be cut to determine the future of American health care. In fact, some even say our seat is a seat at the head of that table. But whatever the seating arrangement, when there is some national action on health care system reform, you can be sure your opinions will be heard

because we are already at the table and we are already taking the national lead to mobilize public opinion and to lobby Congress and the administration for constructive, realistic, workable health care reform before Americans are — literally — dying in the streets!

Because both here in your state — with your outstanding Arkansas Health Care Access Foundation and your Society's good, strong political involvement — and also up in Washington where the American Medical Association has good, strong political involvement, we need to keep the engines stoked. We need to keep our members fired up. We need to keep on going full steam ahead. We need to be so committed to the political process that even the pessimists will have to admit of us that we're steaming along so well nothing will ever stop us!

So, full steam ahead with this convention. And thank you for the privilege of letting me share this meeting with you!

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## Address by Mrs. David Williams

1990-91 President  
Arkansas Medical Society Auxiliary



Mr. Speaker, Dr. Jones, Dr. Warren, House of Delegates, I bring greetings to you on behalf of the 914 members of the Arkansas Medical Society Auxiliary. These 914 members represent 14 organized county auxiliaries, 42 members-at-large, and seven resident student spouses.

I am extremely proud of the participation in the county, state, and national projects that the elected board members, appointed committee chairpersons, and county auxiliaries have accomplished. The AMSA was represented at the National Convention in Chicago last June by four delegates and two alternates. We were proud of Mary Gardner when she was elected to the 1991 Nominating Committee.

Arkansas was represented by nine auxiliaries at Confluence I and II held in Chicago in October and February.

Three auxiliaries represented the Arkansas Medical Society Auxiliary when four students at the University of Arkansas College of Medicine received AMA-ERF scholarships for \$1,000 each.

As Medical Society Auxiliaries, we are pleased to be a part of the Governmental Affairs Council. Seven members of the auxiliary have participated in the newly established Governmental Affairs Council with one member serving as Treasurer of the Council.

The DWI Awareness Project, which was started over two years ago, was concluded on target November 29 with a news conference in the Governor's conference room at the State Capitol. "Is Dying Worth It?" the theme of the contest, challenged students to produce a 30-second video public service announcement warning of the serious consequences of drinking and driving.

First place in the contest, and a \$1,500 college scholarship, went to Chris Hynes, a senior student at Arkansas Baptist High School in Little Rock. Second place and a \$750 scholarship went to three sophomore students from Lakeside High School in Hot Springs. Third place and a \$500 scholarship went to three senior students from Flippin High School. Fourth place and a \$250 scholarship went to two

junior students from Wynne High School.

Each of the final winners were previous winners of the regional level of the contest. At that level, the PSA was in written form only. In all, over 500 entries were submitted from 70 different high schools around the state. The four videos can be available to every television station in the state to air as a public service message.

Three persons were named recipients of the inaugural Ilse F. Oates Scholarships for 1991. A \$500 scholarship was awarded to each of these senior medical students.

The first Martha Harding Gann Memorial Scholarship was awarded last year to a first-year nursing student at North Arkansas Community College in Harrison for the 1990-91 academic year.

The Brooksher Scholarship Fund is accruing money and a scholarship will be awarded from this fund in the future.

The Legislative Committee for the auxiliary is particularly happy to have been a part of the passage of five bills sponsored by or supported by the Arkansas Medical Society. We are pleased to have been a part of the defeat of three bills which we believed to be worthy of defeat.

In following our theme for work this year, "Targeting Volunteerism and Building Community Partnership," county auxiliaries have accomplished much. Examples of these include:

- Cancer screening clinic
- Distribution of "Drug-Free" ribbons, t-shirts
- Contributions to support "Vaccination" projects
- Contributions for purchase of loaner infant car seats
- "Don't Drink and Drive" cards for prom flowers
- Grant to school to deal with adolescent pregnancy problem
- Donation to update health section of county library
- Nursing scholarships
- Single parent scholarship matching fund
- "FYI" booklets distributed to 7-12 graders
- Scoliosis screening for 2,600 students
- "Grubby Bear" presentations
- Crises calling cards distributed
- Teen pregnancy pamphlets distributed to area schools
- Breast self-exam pamphlets distributed at department stores
- Bird feeders installed at nursing homes

Our state AMA-ERF chairperson and the local counties have been successful this year as they have worked to secure over \$26,000 in contributions which will be awarded next year at your annual session.

In my challenge to the AMSA a year ago, I asked that we be more visionary in our planning, more positive in our goal setting, and more powerful with energy to accomplish our goals. I am happy to tell you today that the AMSA has achieved the goals that we had set for this year.

In the coming year, we have selected a statewide health project. We will again need you as we work toward a statewide symposium to address adolescent and teen health needs.

We thank you for your support during 1990-91, and we look forward to your continued support in 1991-92.



## Address by Mrs. Charles Rodgers

1991-92 President-elect  
Arkansas Medical Society Auxiliary



Mr. Speaker, officers of the Arkansas Medical Society:

Thank you for your invitation to speak at your opening session. As incoming president of the auxiliary for 1991-92, I look forward to helping the Society meet its goals in the coming year and I also want to enlist your support for our concerns and projects.

The focus of the year 1991-92 will be the theme: "A New Decade, A New Resolve," because we are approaching the year 2000 and we need a new commitment, a new resolve to the goals of medicine.

We need to ask ourselves - now, what do we want for the medical community by the year 2000?

We ask, first, that you communicate your goals to us and tell us specifically how we can help you.

We ask, second, that you help us with ours.

Our goals for the coming decade will be to support the

medical family and the medical community; to continue fund raising for medical education; to continue political action and lobbying for the concerns of medicine; to continue health promotion and education in the communities where we live; to continue to promote the image of the physician as he or she truly is - a hard-working, caring, and concerned individual.

To meet these goals, we need members, participation, and dues. Dues are support! Encourage your spouse to join, or buy a gift membership for your spouse.

The times - "they are a changin'" - as the song goes, but as the versatile auxiliaries we are, we intend to adjust our sails, to make changes, that will put us on a good course to the future.

We intend to sail confidently on - with flying colors - on to the year 2000.

Won't you join us?





## Address by Mrs. Joe Ed Smith

Director, Southern Region  
American Medical Association Auxiliary



Greetings from our National President, Norma Skoglund of Oregon, and from the 70,000 plus members of the American Medical Association Auxiliary. Our federation is made up of 855 county organizations in 46 states.

Our medical auxiliary's *raison d'être*, is to support medicine and medicine's causes; therefore, your goals are our goals. Auxiliary is an excellent vehicle for carrying "medicine's message" to the peoples of this nation - from north to south, from east to west.

The health care delivery system in this country is the pre-eminent health care delivery system in the world and people travel from all spheres of the globe to utilize it. American medicine is on the cutting edge in quality of medical education and quality health care. Yet, the health care deliverers and the system is under attack.

It is very proper that physicians in this country are taking strong leadership roles in attempting to shape the health care delivery of the future. The American Medical Association's proposed plan, "Health Access America," demonstrates medicine's pro-active stance.

Auxilians are pro-active also and are committed in time, energies, and talents to aiding you in your endeavors to insure that quality health care is in reach of every citizen of this land.

Commitment to volunteerism, leadership, and action has long been the key to auxiliary's success. We are enjoying another good year.

Our programs and projects to solve community health problems have benefitted every age segment of society from the unborn to the elderly. This past year we've done 6,000 community health programs to help people live healthier lives. We distributed more than 70,000 "Be a Winner"

booklets to elementary schools nationwide.

In the auxiliary year 1989-90, we raised more than \$2 million to support the American Medical Association Education and Research Foundation. This year our goal is \$2.2 million and it looks like we are going to reach it.

Auxilians are active players in the legislative arena. We are involved in issues that ranged from drunk driving prevention and seat belt use, to physician reimbursement and tort reform. We have phone banks established in every state to be used as needed.

We made establishing relationships with the media a priority this year and were rewarded with excellent news coverage of the volunteer efforts of physicians and spouses. This "Building Bridges Campaign" has great potential in public relations.

A new emphasis for the AMA auxiliary, in cooperation with the AMA, will be "Violence in America." This program will focus on interpersonal violence, including battered women, rape, child abuse, and violence among teens. It will be introduced at our Annual Session in June.

Our ability to achieve is due to our partnership with you...the physicians across the nation.

We thank you for your support.

Author Peter Drucker, founding father of the science of management, says "The best way to predict the future is to create it." Our medical society/auxiliary partnership and unity, will allow us to express our opinions, manifest our strengths, and exert our influence as one in creating this future. Let us trust our hopes not our fears as we move toward the new millennium.

The future may be beyond our vision, but it is not entirely beyond our control.



# Arkansas Medical Society Auxiliary Convention Report

Mrs. William Harrison

The 67th Annual Session of the Arkansas Medical Society Auxiliary was a well planned meeting that was enjoyed by all who attended. The business was conducted with such efficiency that auxiliarians had time to view the exhibit area, or to relax, or to enjoy visiting Hot Springs.



A leadership confluence was held on Thursday preceding the annual session. Training was offered to state and county officers. Auxiliarians were updated on current developments affecting medicine in their communities, as well as, training sessions in the areas of fund raising, parliamentary procedure, recording minutes, finding available monies for projects, and effective legislative lobbying. Mrs. Seleena Ellis of the Arkansas State Department of Volunteerism was the featured speaker. She spoke of forming community coalitions, availability of state grant monies, and presented information concerning a new volunteer mentoring program.

Featured speakers for the Annual Session included Mrs. Joe Ed Smith (Mary Lynn), director, Southern Region, American Medical Association Auxiliary and Mrs. William B. Shelton (Emily), president-elect, Southern Medical Association Auxiliary. They brought greetings and told of upcoming plans for their groups.

Joycelyn Elders, M.D., director, Arkansas Department of Health spoke on the concerns and problems facing Arkansas youths. Accused by some of being the "education director," she explained how health and education are inter-related; development of one cannot progress without development of the other.

Arvil Burks, Ed.D., University of Central Arkansas, and Gary Parish, program advisor, Comprehensive School Health, State Department of Education, spoke on the national program, "Healthy Youth 2000."

The Arkansas Medical Society Auxiliary is happy to report that auxiliarians throughout the state have raised a total of \$25,542.21 for AMA-ERF to be donated to the University of Arkansas Medical School. The state health project - "Is Dying Worth It?" DWI campaign - was completed with the presentation of scholarships to top four winning entries. The auxiliary has presented three scholarships to senior medical students and full scholarship for one student nurse. Auxiliarians have been very active legislatively this year with phone calls and personal contacts with their Senators and Representatives concerning medical and health legislation. The Auxiliary had a total membership of 931 for 1990-91, and that is 54 more than 1989-90.

During the meeting, plans were announced for a new state health project. A committee was formed to plan for an "Adolescent Health Symposium." Initial plans call for this



to be a one-day event with talks by health professionals, question and answer sessions, and break-out discussion groups. This will involve high schools students, teachers, and counselors from around the state.

This has been a very productive year for AMSA and we are looking forward to all the activities involved in our continued support of the Arkansas Medical Society in 1991-1992.



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## 1991 Scientific Exhibitors

*Cervical Spine Instability in Rheumatoid Patients*; David Collins, M.D., C. Lowery Barnes, M.D., and Richard Fitzrandolph, M.D.

*Personality Disorders with Somatization Disorders*; George Hamilton, M.D., Frank Kane, M.D., and Barbara O'Brien, M.S.

*Plastic & Reconstructive Surgery*; Luther Walley, M.D.

*Renal and Biliary Lithotripsy*; David Harshfield, M.D. and Steven Teplick, M.D.

*Ultrasound Diagnosis of Fetal Gastrointestinal Abnormalities*; Teresita Anguaco, M.D., Steven Miller, M.D., and J. Gerald Quirk, M.D.

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## 1991 Associate Exhibitors

Arkansas Society of Medical Assistants, Inc.  
Arkansas Medical Group Management Association  
History of Medicine Associates  
Regional AIDS Interfaith Network (R.A.I.N.)

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## In Memoriam

### Society Members

Keith E. Ashcraft, M.D., Little Rock  
Daniel H. Autry, M.D., Little Rock  
Van C. Binns, M.D., Monticello  
Lucas Byrd, M.D., Little Rock  
Don W. Chamblin, M.D., Fort Smith  
Beresford L. Church, M.D., North Little Rock  
H. Blake Crow, M.D., Prescott  
Junius B. Futrell, M.D., Rector  
Onyx P. Garner Sr., M.D., New Orleans, LA  
George G. Graham, M.D., Little Rock  
William A. Hudson, M.D., Harrison  
R. Paul Hughes, M.D., Texarkana  
Virgil N. Kennedy, M.D., Fort Smith  
Walter H. Lane, M.D., Dover  
James G. Martindale, M.D., Hope  
Ross E. Maynard, M.D., Pine Bluff  
James R. Morrison, M.D., Little Rock  
Thomas J. Simpson, M.D., Harrison  
William J. Tolleson, M.D., Bull Shoals



### Auxiliary Members and Spouses

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Mrs. James A. Brown (Shirley R.), Fort Smith  
Mrs. Neil Compton (Laurene P.), Bentonville  
Mrs. Richard B. Dickinson (Valerie J.), DeQueen  
Mrs. Joseph L. (Virginia J.) Ellis, Camden  
Mrs. S.C. Fulmer (Pauline), Little Rock  
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Mrs. Alvin W. Strauss Jr. (Leslie), Little Rock  
Mrs. Carl L. Wilson (Bette W.), Fort Smith

# Fifty Year Club



*The Fifty Year Club is composed of physicians who, for the past fifty years, have loyally and effectively served the community and, by skill and devotion to high ideals, upheld and maintained the standards of the medical profession.*

*Officers for 1991-92 are Henry V. Kirby, M.D., Harrison, president; and James Smith, M.D., Little Rock, vice president.*

*Physicians attending the Fifty Year Club luncheon were: Drs. John Ashley, Robert Atkinson, Max Baldrige, L. O. Bohnen, James Branch, Robert Burger, Gilbert Dean, Edgar Easley, Ross Fowler, David Fried, John Greutter, John Guenthner, William Harrell, John Hundley, James Huskins, W. E. Jennings, Albert Koenig, Agnes Kolb, Jim McKenzie, A. C. Modelevsky, Frances Rothert, Ben Saltzman, Kenneth Seifert, James Smith, Bryant Swindoll, and H. W. Thomas.*



# 1991 AMS Grand Prize Winners

## Cancun, Mexico

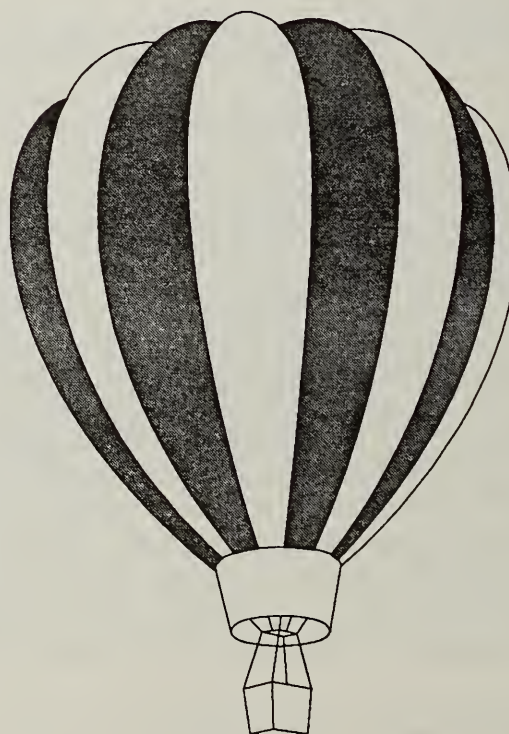


*Dr. Fred Nagel, of Little Rock, was the winner of the physician grand prize drawing held at the 115th Annual Session of the Arkansas Medical Society. He and Mrs. Nagel will enjoy a 4 day/ 3 night vacation in a 5-star hotel compliments of Tours and Travel of Russellville.*

## Champagne Flight



*Mr. David Owens, of the Doctors and Nurses Weight Control Center, was the winner of the exhibitor grand prize drawing held at the 115th Annual Session of the Arkansas Medical Society. He and a guest will enjoy a Champagne Flight for two aboard a hot air balloon compliments of the Arkansas Medical Society.*





# 1991 AMS Golf Tournament Champions and Teams



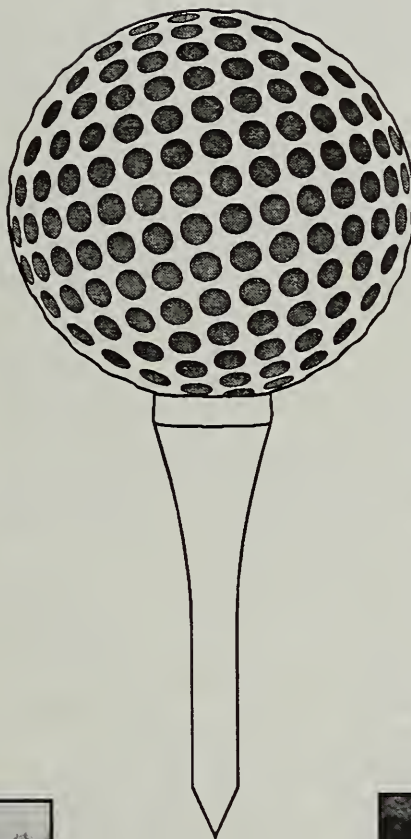
*Co-Champions: Dr. David Barclay,  
Mr. Doug Pope, Dr. David Harshfield,  
and Dr. Gilbert Dean.*



*Co-Champions: Dr. James Huskins,  
Mr. Chris Beagle, Mr. Bill McCormick,  
and Dr. Bud Purdy.*



*Dr. Kelsy Caplinger, Dr. John Crenshaw,  
Mr. Bruce Branscome, and Mr. Tom Cum-  
mings.*



*Dr. Charles Logan, Dr. Bill McGowan,  
Dr. Fred Nagel, and Dr. Stanley Apple-  
gate.*



*Dr. A. E. Andrews, Mr. Bill Proffer,  
Mr. John Gilbert, and Mr. Terry Brown.*



*Mr. Dale Emmerling, Dr. David Rogers,  
Mr. Mike Johnson, Dr. Bill Nowlin, and  
Dr. Joe Ed Smith.*



# AMS Newsmakers

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**Dr. James S. Adamson**, a Little Rock internist and pulmonologist, recently assumed office as governor for the Arkansas Chapter of the American College of Physicians (ACP). Dr. Adamson is chief of staff at Baptist Medical Center and is a consultant to the State Health Department.

**Dr. Kelsy J. Caplinger III**, of the Little Rock Allergy Clinic, has been presented the Special Achievement Award by the American Academy of Pediatrics for his distinguished leadership in founding and serving as chairman of the Board of Directors of Med Camps of Arkansas.

The **Fort Smith Rehabilitation Hospital** was presented the Special Achievement Award for the year 1990 for outstanding performance based on evaluations and compliance with national standards and excellence achieved in patient care. Fort Smith Rehabilitation Hospital is the only hospital to have received the award for two consecutive years.

The University of Arkansas for Medical Sciences has selected **Irol Torin Gray** as the recipient of the sixth annual "Dr. Horace N. Marvin Award" for outstanding academic achievement in microscopic anatomy.

The Pulaski County Medical Society has elected its officers for 1991. They are: **Dr. Ashley S. Ross**, president; **Dr. R. Jerry Mann**, president-elect; **Dr. D.B. Allen**, vice president; **Dr. Joseph M. Beck**, secretary; **Dr. Robert G. Valentine Jr.**, treasurer; and **Dr. Charles P. Fitzgerald**, treasurer.

**Dr. Michael Townsend**, associated with the Rogers Diagnostic Clinic, has been awarded diplomate status from the American Board of Internal Medicine.

**Dr. Kent Westbrook**, professor of surgery at UAMS and the director of the Arkansas Cancer Research Center at UAMS, has been awarded a grant for support of professors of clinical oncology from the American Cancer Society, Arkansas Division. This is one of four such awards in the nation. Dr. Westbrook is one of only 16 professors in the country to receive this award, and the first ever in Arkansas.

The Rebsamen Regional Medical Center Development Foundation in Jacksonville has elected **Dr. Thomas H. Wortham**, of the Marshall Road Medical Surgical Clinic, as president of the Foundation.

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(501) 675-2800 (principals only please)

# New Members

## CRAIGHEAD/POINSETT COUNTY

**Warner Jr., Robert L.**, Cardiovascular/Thoracic Surgery, Jonesboro. Born February 12, 1957, Mobile, AL. Medical education, University of Mississippi School of Medicine, Jackson, 1983. Internship, Medical University of South Carolina, Charleston, 1984. Residency, Medical University of South Carolina, Charleston, 1988; University of Mississippi School of Medicine, Jackson, 1990.

## GARLAND COUNTY

**Thomas, Paul Chu**, Dermatology, Hot Springs. Born June 20, 1958, Forrest City. Medical education, University of Tennessee, Memphis, 1984. Internship/residency, University of Tennessee, Memphis, 1990. Pending certification.

## MILLER COUNTY

**Northam, Jon M.**, OB/GYN, Texarkana, TX. Born January 27, 1959, Texarkana, TX. Medical education, University of Texas Health Science Center Medical School, San Antonio, 1981. Internship, UTHSC, San Antonio, 1986. Residency, Tulane University Medical School, 1991. Board qualified.

## PULASKI COUNTY

**Capps II, Dwight H.**, Ophthalmology, Little Rock. Born April 29, 1955, Protland, OR. Medical education, UAMS, 1985. Internship/residency, UAMS, 1986. Practice experience, 5 years.

**Johnson, Carl L.**, Internist, Little Rock. Born March 20, 1959. Medical education, UAMS, 1986. Internship/residency, UAMS, 1989. Board eligible.

**Parks, Greta**, Family Practice, Little Rock. Born September 7, 1960, Lewisville. Medical education, UAMS, 1987. Internship/residency, UAMS, 1990. Board certified.

## RESIDENT

**Anthony, Marianne N.**, Radiology. Born February 17, 1965, Ft. Smith. Medical education, UAMS, 1991. Residency, UAMS.

**Blackstock, Terri T.**, Internal Medicine. Born February 28, 1959, St. Joseph, MO. Medical education, UAMS, 1991. Internship/residency, UAMS.

**Bolli, Jo-Ann T.** Born August 9, 1956, Providence, RI. Medical education, UAMS, 1991. Internship/residency, UAMS.

**Daniels, Charles D.**, Orthopaedic Surgery. Born December 10, 1964, Little Rock. Medical education, UAMS, 1991. Internship/residency, UAMS.

**Quinn III, John J.** Born July 7, 1965, Bridgeport, CN. Medical education, UAMS, 1991. Internship/residency, UAMS.

**Schemel, Lawrence J.**, Family Practice. Born March 19, 1964, Buffalo, NY. Medical education, UAMS, 1991. Residency, University of Oklahoma, Tulsa.

**Shields, Eddie**, Pediatrics. Born August 27, 1963, Hot Springs. Medical education, UAMS, 1991. Internship, UAMS.

**Stewart, Tracy D.** Born April 24, 1950, Oklahoma City. Medical education, UAMS, 1991. Internship, Arkansas Children's Hospital, Little Rock.

**Thomason, Steven L.**, Family Medicine. Born February 13, 1965, Little Rock. Medical education, UAMS, 1991. Residency, AHEC-NE, Jonesboro.

**Webb, Sherilyn M.**, Family Medicine. Born September 11, 1953, San Diego. Medical education, UAMS, 1991. Residency, University of Wyoming, Casper, WY.

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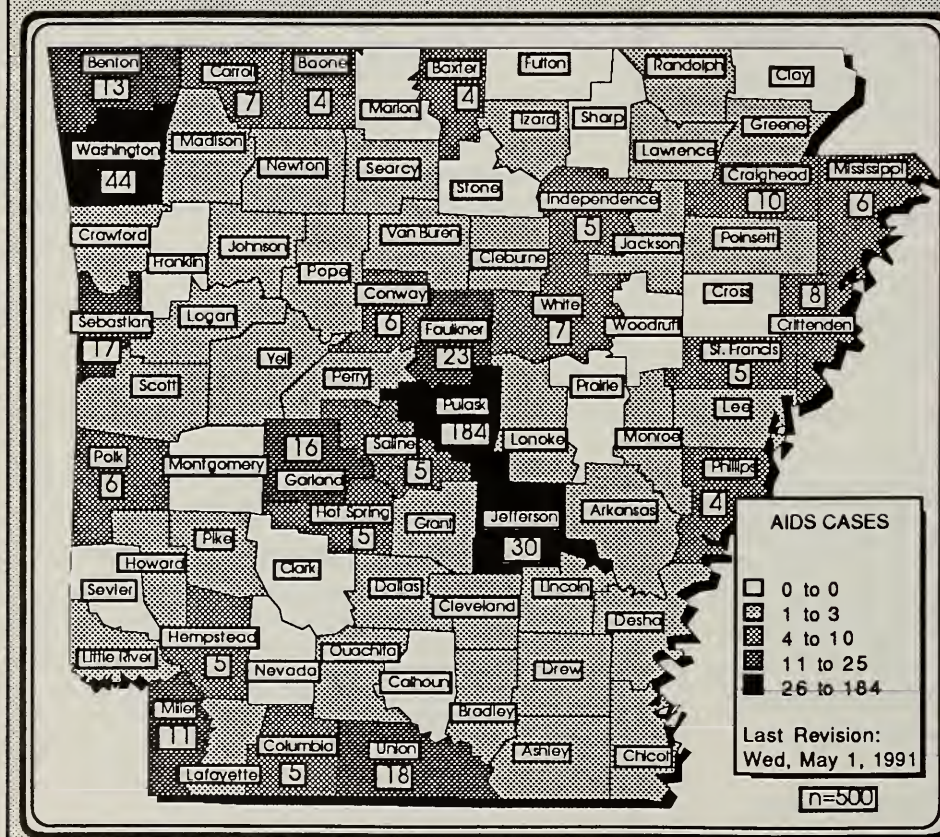
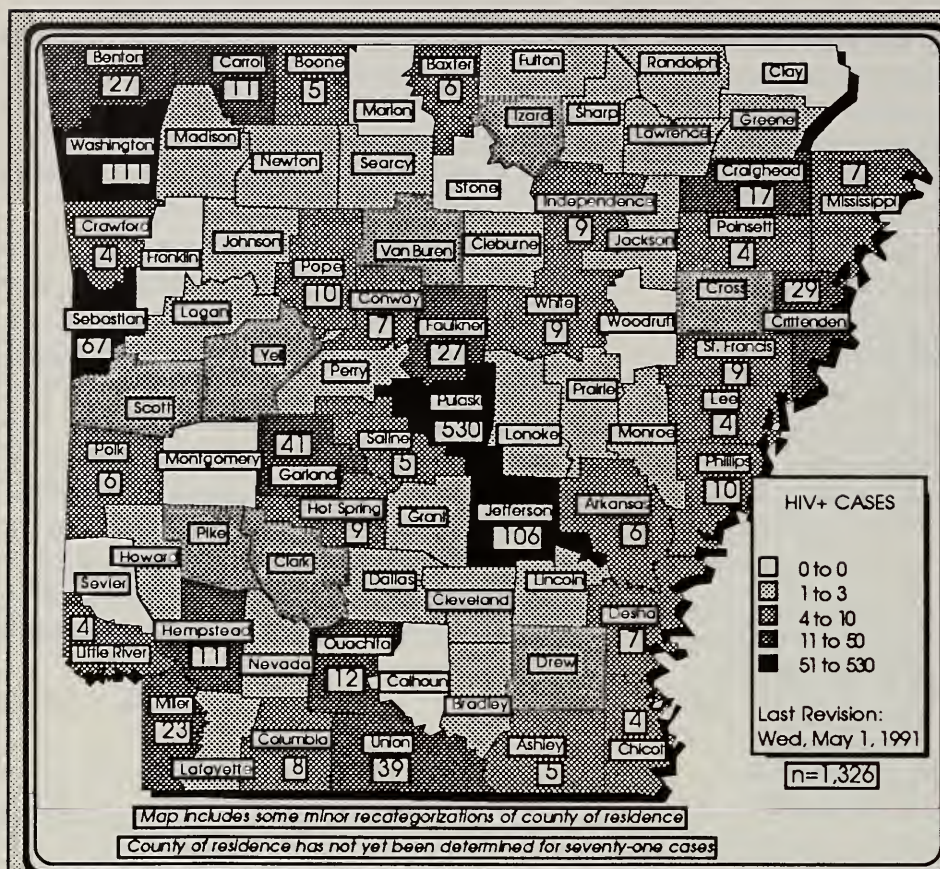
P.O. Box 3398  
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# Arkansas HIV/AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statutes 20-15-904, 15-14-123, 16-82-101 and Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

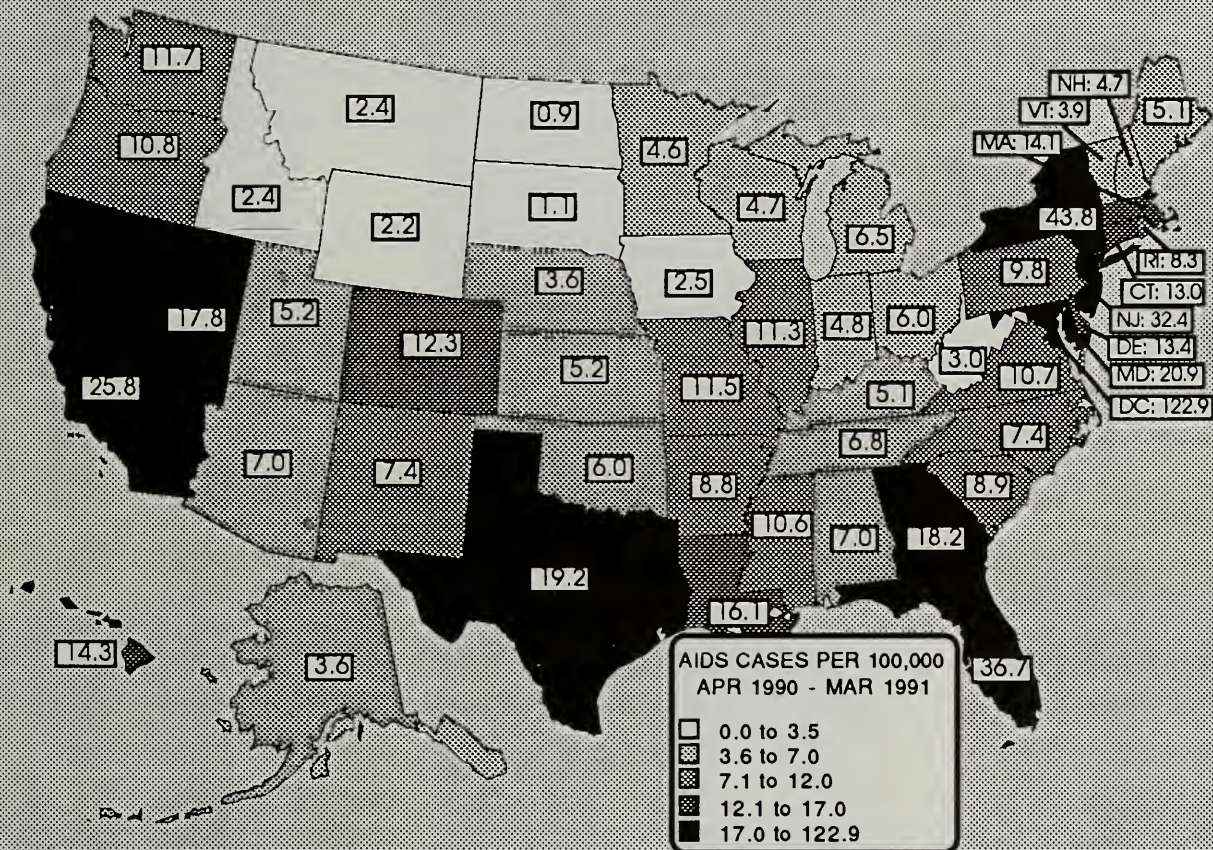
Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# Arkansas AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: APR '90 -MAR '91	206	Reported: APR '90 -MAR '91	43,532
Rates per 100,000 population: APR '90 -MAR '91	8.8	Rates per 100,000 population: APR '90 -MAR '91	17.2
Cumulative Reports: 1983 - APR '91	500	Cumulative Reports: 1980 -MAR '91	171,876
Adult	488	Adult	168,913
Pediatric	12	Pediatric	2,963
Deaths: 1983 -APR '91	288	Deaths: 1980 - MAR '91	108,731
Adult	282	Adult	107,210
Pediatric	6	Pediatric	1,521
Mortality Rate	57.6%	Mortality Rate	63.3%



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	64.0%	Gay or Bisexual Men	58.1%
Gay or Bisexual Men who used IV Drugs	9.8%	Gay or Bisexual Men who used IV Drugs	6.5%
Heterosexual IV Drug Users	10.2%	Heterosexual IV Drug Users	21.2%
Heterosexual contact with person at risk	5.2%	Heterosexual contact with person at risk	5.3%
Hemophilia	1.8%	Hemophilia	0.9%
Transfusion with blood products	3.8%	Transfusion with blood products	2.4%
Perinatal	1.8%	Perinatal	1.4%
Risk unknown at this time	3.4%	Risk unknown at this time	3.7%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



Dear Carl,

Congratulations on your new medical staff leadership position! Now you're not only a physician — you need to be a manager, negotiator, arbitrator, and even a parliamentarian. I wish I had received some special training when I first took a position like yours!

Sincerely,  
Helen

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- Manage medical staff affairs
- Develop bylaws that enhance staff effectiveness
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# Radiological Case of the Month

John R.E. Dickins, M.D.  
David L. Harshfield, M.D.  
Steven R. Nokes, M.D.

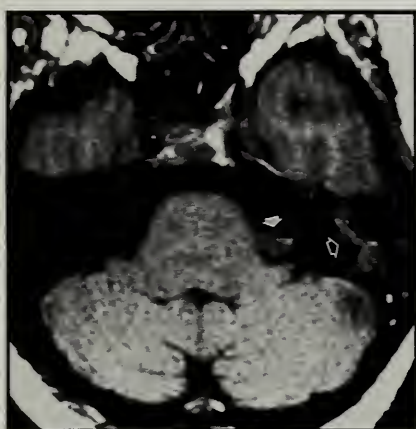
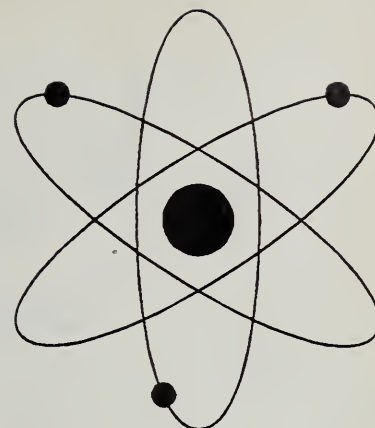


Figure 1a.  $T_1$ -weighted axial image of the internal auditory canal (IAC).



Figure 1b. Gd-enhanced  $T_1$ -weighted axial image of the IAC.

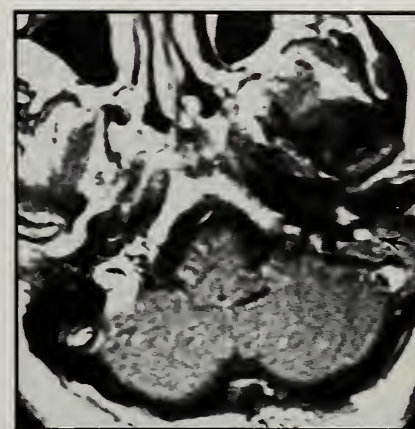


Figure 1c. Gd-enhanced  $T_1$ -weighted axial image at the level of the stylomastoid foramen.



Figure 2a. Axial CT image at the IAC.

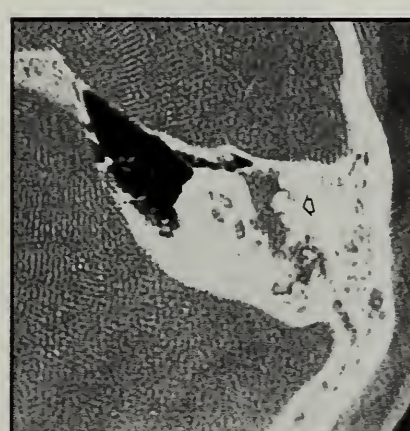


Figure 2b. Axial CT image at the middle ear.



Figure 2c. Axial CT image at the stylomastoid foramen.

## History:

A 43 year-old woman with a progressive left facial palsy and conductive hearing loss



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## Left Facial Neuroma (schwannoma)

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### Findings:

The MR images reveal an enhancing mass in the left cerebellopontine angle (white arrows) extending into the middle ear (open white arrows) and to the stylomastoid foramen. Nonenhancing fluid is present in the mastoid air cells. The CT study reveals the mass in the middle ear displacing the ossicles (black open arrow) laterally. (This accounts for the conductive hearing loss.) The internal auditory canal and descending facial nerve canal are dilated. The enhancing mass in the C-P angle could be confused with an acoustic neuroma, but the lesion extends along the entire course of the facial nerve allowing a confident preoperative diagnosis.

### Discussion:

Imaging of the temporal bone has changed dramatically over the last two decades. Conventional radiography, pluridirectional tomography and selective angiography have been supplanted by high resolution computed tomography (CT), magnetic resonance (MR) imaging and digital subtraction angiography (DSA). Since the availability of MR imaging, intravenous contrast enhancement is rarely necessary for CT evaluation. Ct remains the mainstay of evaluation for trauma, chronic otitis media, cholesteatoma, pulsatile tinnitus and conductive hearing loss. MR imaging (with gadolinium) is indicated in sensorineural hearing loss and vertigo. MR is 100% sensitive to acoustic neuromas, while CT varies from 58% - 65% in accuracy. For facial palsy MR and CT are complementary. Ct better depicts the labyrinthine and tympanic portions of the facial nerve, while MR is superior for nuclear, supranuclear and mastoid lesions.

Facial nerve neuromas account for less than 5% of facial palsies. Eighty percent of facial nerve palsies are idiopathic (Bell's palsy). Classically, Bell's palsy has a rapid onset, while a palsy of neoplastic origin is slowly progressive. Trauma, herpes zoster oticus and otitis media are all more common causes of a facial nerve palsy than is a facial neuroma. Bell's (idiopathic) facial palsy is a diagnosis of exclusion and seldom requires radiographic analysis. Imaging studies are indicated in patients whose facial palsy persist for longer than two months or in whom associated clinical features are atypical, such as slowly progressive palsy, facial spasm preceding the palsy, recurrent palsies, unusual degrees of pain, and multiple cranial neuropathies. While these atypical presentations occur in up to 20% of patients with Bell's palsy, neoplastic (acoustic or facial neuromas, parotid tumors, brain stem tumors), infectious (mastoiditis, cholesteatoma) or degenerative (multiple sclerosis) disease affecting the nerve must be excluded.

### References

1. Swartz JD. Current imaging approach to the temporal bone. *Radiology* 1989; 171:309-17.
2. Latack JT, Gabrielson SO, Krake JE, et al. Facial nerve neuromas: radiologic evaluation. *Radiology* 1983; 149:731-39.
3. Tien R, Dillon WP, Jackler RK. Contrast-enhanced MR imaging of the facial nerve in 11 patients with Bell's palsy. *AJNR* 1990; 11:735-41.

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*Contributor: John R.E. Dickins, M.D., is in private practice and is affiliated with the Ear and Nose-Throat Clinic in Little Rock.*

*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

12

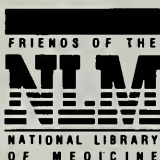
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# Medicine in the News

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## Access To Care Receives Grant

Arkansas Health Care Access Foundation, Inc., the Physician's Care Program for indigent Arkansans, is the recipient of a \$500 grant awarded by the Arkansas Public Health Association. The association awards only one grant each year, to a non-profit, health related institution. In choosing the recipient, the Health Association panel considers the value and scope of the project, public health applicability and population served.

Pat Keller, Program Director and Susan Rish, Assistant Director received the award along with a plaque recognizing Arkansas Health Care Access, at the Arkansas Public Health Association Conference, held at the Pine Bluff Convention Center on April 17, 1991.

The Arkansas Health Care Access Foundation, Inc. has provided access to low cost or free medical care to over 3,000 Arkansans. The result of a recent survey of the Foundation shows the average income of these eligible applicants is 44% of the Federal Income Poverty Level.

According to Pat Keller, the entire grant will be used to supplement some of the cost of the prescriptions, whenever the applicant is financially unable to afford the prescribed medications at a discount. A large number of Arkansas pharmacies are providing prescriptions at wholesale cost to the referred applicants. Some of the volunteer pharmacies have filled prescriptions at no cost to the referred individual.

As of May 1, 1991, the Arkansas Health Care Access Foundation has provided free medical services to 2,747 medically indigent persons.

The program has 1,448 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## World Diabetes Day

Growing concern among national health officials about the escalating incidence and toll of diabetes throughout the world compelled the International Diabetes Federation (IDF) and the World Health Organization (WHO) to proclaim June 27, 1991, the first-ever World Diabetes Day.

"World Diabetes Day has influenced an unprecedented union of international diabetes organizations, government health organizations and industry leaders to reach out to an estimated 120 million people with diabetes throughout the world — many of whom do not even know they have the disease — by sharing information about the latest research and treatment to help them identify and

control this devastating disease," stated International Diabetes Federation president-elect, Wendell Mays Jr. "Our objective is to garner long overdue and meaningful attention to this deadly killer among the public and media, so we can begin to educate people about the symptoms and treatment of diabetes."

## Interest in Living Wills

Fourty-one states currently have living will statutes and 22 have statutes recognizing a durable power of attorney for health care, the Council on Ethical and Judicial Affairs said in a report to the Board of Trustees. Although the vast majority of people support the use of advance directives, only about 5% to 10% of adults have them. The U.S. Supreme Court decision in Cruzan vs. Director, Missouri Department of Health increased public interest in living wills. The number of requests for sample living wills and similar documents from the Society for the Right to Die increased 500% after the Supreme Court's decision last June. In addition, passage of the AMA-supported patient Self-Determination Act of 1990 is likely to increase the number of people who use living wills. When the act takes effect in December 1991, any health care facility that receives Medicaid or Medicare funds will be required to inform patients about the right-to-die options.

## Locum Tenens Services Available

The American Medical Association announces a service for physicians and practices seeking short-term, locum tenens opportunities. The AMA's Locum Tenens Service provides recruiters and physicians with the widest possible exposure through listing locum tenens positions in AMA's Opportunity Placement Register and through presenting abbreviated curricula vitae of physicians in the AMA's Physician Placement Register. Complete physician curricula vitae can be ordered through the service by practices seeking locum tenens physicians. Physicians can also request profiles of practices offering locum tenens positions.

For more information regarding the AMA's Locum Tenens Service, please contact Hattie Askew, project coordinator, Locum Tenens Service, at the AMA's Physicians Career Resource, American Medical Association, P.O. Box 10012, Chicago, IL 60610, or call 1-800-955-3565.

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CROSSOVER CLAIM

EDS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER

PLACE OF SERVICE CODE

HICFA

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING

LEDGER CARDS

WRITE-OFF

PARTICIPATING PHYSICIAN

ROOM

INSURANCE CARDS

GROUP POLICY NUMBER

CHARGE SLIPS

MEDICARE

DISABILITY

PATIENT STATEMENTS

RELATIONSHIP TO THE INSURED

PAYMENT

APPROVED AMOUNT

AMOUNT

TYPEWRITER

APPOINTMENT BOOK

EXAMINATION ROOM

TICKLER FILES

CODING REQUIREMENTS

SELF PAYS

MEDICAID

ATTENDING PHYSICIAN PPO/HMO

DATE OF DISABILITY

DATE OF ACCIDENT

PATIENT RECORDS

RESPONSIBLE PARTY

INDIVIDUAL POLICY NUMBER

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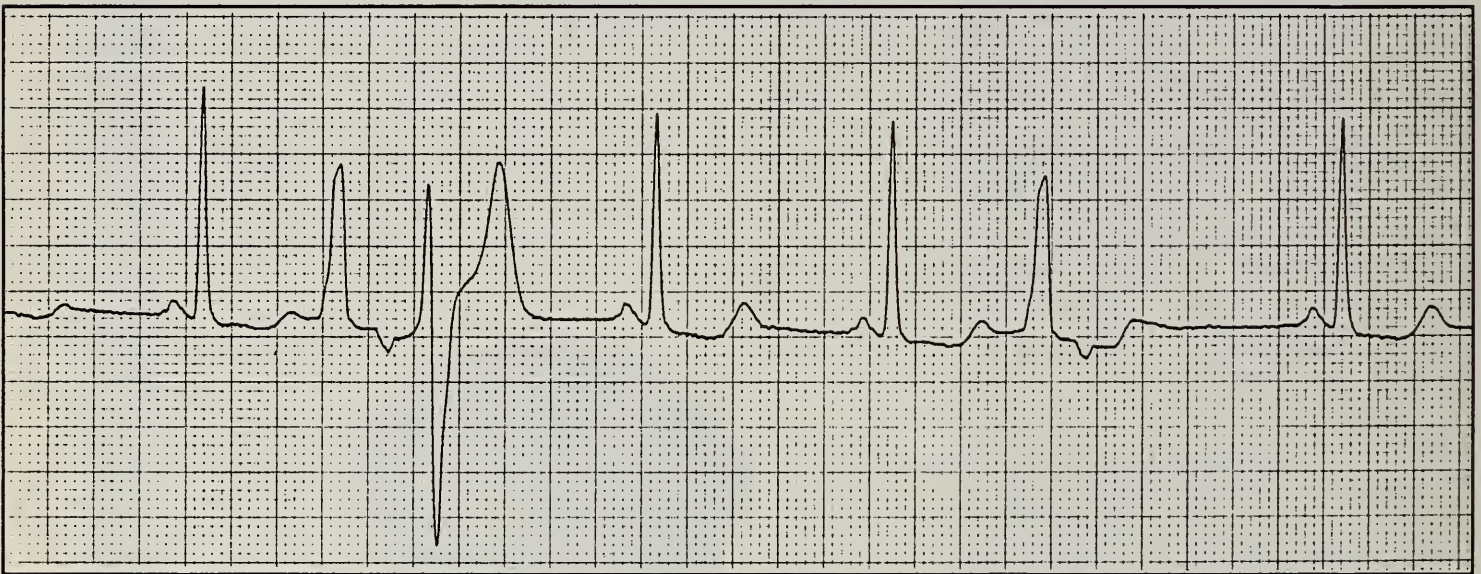


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## CLINICAL HISTORY:

This record was obtained from a 59 year-old male.



## DISCUSSION:

The basic rhythm is normal sinus. The rate is 60 beats per minute and the PR interval is 0.14 sec. The third complex is a premature ventricular complex (PVC) with a coupling interval of 0.56 sec. The fourth complex is a ventricular echo. This complex occurs 0.18 sec following a negative (retrograde) P wave. The fifth and sixth complexes are normal sinus complexes and the seventh is again a PVC. This PVC has a coupling interval of 0.62 sec and is also followed by a retrograde P wave which fails to reciprocate to the ventricle.

It is important to be able to differentiate between ventricular echoes and the PVCs. In this example, the first PVC is followed by a wide complex of different morphology suggesting multifocal PVCs occurring in pairs. In an appropriate clinical setting, this finding might prompt one to institute antiarrhythmic therapy. However, careful inspection of the preceding ST segment reveals the negative P wave followed by a QRS with an appropriate PR interval. Recognition of ventricular echoes may allow one to avoid institution of antiarrhythmic therapy when it is not necessary.

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# Things To Come

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## June 17-19

**Breast Cancer Diagnosis: Interventional Procedures.** The Westin Resort, Hilton Head, SC. Sponsored by Siemens Medical Systems, Inc. For more information, call Ted Pensiero (908) 906-3807 or Jenny Adamiec (908) 906-3800.

## June 28-30

**Frontiers in Endosurgery.** Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862.

## July 5-7

**Sports Medicine Symposium.** Shell Island Hotel, Wrightsville Beach, NC. Sponsored by the Medical Aspects of Sports Committee of the North Carolina Medical Society and the Greensboro AHEC. Fee: \$70. CME credit available. For more information, call (919) 833-3836.

## July 20-27

**9th Annual Medical Seminar.** Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. Sponsored by North Memorial Medical Center and the University of Minnesota Department of Family Practice and St. John's Regional Health Center. CME Category I available. For more information, call (612) 588-9478.

## August 1-3

**Financial Management Conference.** Mariner's Inn, Hilton Head Island, SC. Sponsored by the Medical College of Georgia. For more information, call Donald Murphy or John Norcross at 1-800-221-6437.

## August 21

**1991 General Loss Prevention Seminar.** Airport Hilton Inn, Memphis, TN. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## August 22

**1991 General Loss Prevention Seminar.** Airport Hilton Inn, Memphis, TN. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## October 13-17

**Joint Meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology.** Anaheim Convention Center, CA. Sponsored by the American Academy of Ophthalmology. For more information, contact Linda Whitfield, (415) 561-8500.

### Family Practice Physician

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For more information, contact: Barbara Carter, Administrator, Oakwood Family Medical Center, Missouri Pacific Employee's Health Association, 7709 Hwy 107, Sherwood, Arkansas 72116. Or call, (501) 834-1902.

**Emergency Medicine:** Opportunities are available at client hospitals in Arkansas and Texas. **Hope, Arkansas:** Emergency department medical director and staff opportunities. 75-bed hospital with annual ED volume of 8,000. **Hot Springs, Arkansas:** 3 year old, 150-bed hospital. **Texarkana, Texas:** Full-time ED opportunities at 110-bed facility. Annual ED volume 10,200. Spectrum makes available to independent contract physicians competitive fees, occurrence-based malpractice insurance program, allowance for CME and professional dues, and assistance with relocation expenses. Director also offered health benefits, administrative stipend, and, after 12 months, participation in a 401k plan. For more information, contact Ron Hamilton, Spectrum Emergency Care, PO Box 27352, St. Louis, MO 63141; 1-800-325-3982, ext. 3049.

# Keeping Up

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## **Organ Donation: Second Chance for Life**

June 18, 7:00 p.m., Education Building, Baxter County Regional Hospital. Sponsored by Baxter County Regional Hospital and presented by George Evanoff, M.D. Category I credits offered.

## **Infertility Diagnosis and Work-up**

June 19, 12:00 noon, Sparks Regional Medical Center. Sponsored by AHEC Fort Smith and presented by Glenn Weitzman, M.D. Category I credit offered.

## **1991 General Loss Prevention Seminar**

June 22, 9:00 a.m. 11:00 a.m., Best Western InnTowne, Little Rock. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## **Advanced Electronic Fetal Monitoring**

July 12, 7:30 a.m. - 3:30 p.m., UAMS Education II G-137, Little Rock. Jointly sponsored by the Arkansas High Risk Pregnancy Program-UAMS Department of OB/GYN, Arkansas Children's Hospital, The University Hospital, and UAMS Continuing Education for Physicians. Category I credit available. Fees: \$25.00. For more information, call 686-5261.

## **1991 General Loss Prevention Seminar**

July 20, 9:00 a.m. - 11:00 a.m., Hilton Hotel, Fayetteville. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## **AAFP 44th Annual Scientific Assembly**

August 1-4, Excelsior Hotel/Statehouse Convention Center, Little Rock. Sponsored by Arkansas Academy of Family Physicians. Nineteen AAFP prescribed hours. For more information, call Carla Coleman at (501) 223-2272.

## **The Seasonal Child**

September 17, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building. Sponsored by Arkansas Children's Hospital. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **The Seasonal Child**

December 3, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building. Sponsored by Arkansas Children's Hospital. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

CME Luncheon, second & fourth Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

### **FAYETTEVILLE - VA MEDICAL CENTER**

Medical Conference (varying topics), third Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom



### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Sleep Disorders Case Conference*, first & third Thursday, video production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, second Friday, 12:00 noon. LaHarpe Room. Sandwich buffet is served  
*Cancer Conference*, third Thursday, 12:00 noon, Laboratory conference room. Lunch is provided  
*Hematology-Oncology Conference*, second Thursday, 12:00 noon. Lunch is provided  
*Interhospital Urology Grand Rounds*, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments are provided  
*Pulmonary Conference*, second & fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet is served  
*Journal Club*, every Tuesday, 12:00 noon, Lunch is provided  
*GYN Surgery Cancer Conference*, second Monday, 12:00 noon. Lunch is provided  
*Joint Tumor Conference*, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch is provided

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, third Thursday, 7:00 a.m., conference room 1  
*GI Conference*, fourth Friday, 12:00 noon, conference room #1. Lunch is provided  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch is provided  
*Pathology Conference*, first Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch is provided  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch is provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch is provided

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

### **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B



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- Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; second & fourth Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B
- Arkansas Blood & Cancer Society Conference*, sixth Thursday, 7:30 p.m. Terrace Restaurant, Little Rock
- CARTI North Tumor Board Cancer Conference*, second Wednesday, 12:00 noon, CARTI North, Searcy
- Cardiothoracic Surgery Conference*, date, time, & location varies
- Cardiothoracic Surgery Monthly Journals Club*, fourth Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
- Cardiothoracic Surgery Morbidity & Mortality Conference*, second Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D
- Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B
- Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B
- Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B
- Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B
- Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29
- GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293
- Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room
- LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month
- LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC
- Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B
- Med/Path Conference*, third or fourth Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306
- Medicine Research Conference*, three Wednesdays a month, 4:30 p.m. UAMS Education Bldg. room B/135
- Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH
- Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours
- Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33
- Ob/Gyn Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B
- Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours
- Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135
- Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours
- Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135
- Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135



*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, first Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, fourth Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, second, third, & fourth Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Tumor Conference*, Tuesdays, 4:00 p.m., VAMC-LR, Pathology conference room

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, first & fourth Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, third Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, second Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, first, second & fourth Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, second Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, fourth Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, first, second & third Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

*Behavioral Sciences Conference*, third Wednesday, 12:00 noon, Washington Regional Medical Center  
*City Hospital Staff Medical Meeting*, second Friday, 12:00 noon, Fayetteville City Hospital  
*Family Medicine Conference*, first, third, fourth Thursday; fourth Wednesday; second Thursday (odd months) AHEC-NW  
*Interesting Case Conference*, 1st & 3rd Friday, 12:00 noon, Fayetteville City Hospital  
*Medicine Conference*, first & third Tuesday, 12:00 noon, Washington Regional Medical Center  
*OB/GYN Conference*, June 13, 12:00 noon, AHEC conference room  
*Pediatric Conference*, second Wednesday, 12:00 noon, Washington Regional Medical Center  
*Radiology Conference*, June 5  
*Surgery Conference*, second Tuesday, 12:00 noon, Washington Regional Medical Center Fulbright Board room

## **FORT SMITH - AHEC**

*Neuroradiology Conference*, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, first & third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, second Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, first Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, fourth & fifth Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, third Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, third Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, second Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, third Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, 2nd Thursday, 4th Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, third & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria

*White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom*

### **PINE BLUFF-AHEC**

*Behavioral Science Conference, first & third Thursday, 12:00 noon, Jefferson Regional Medical Center*

*Chest Conference, second & fourth Friday, 12:00 noon, Jefferson Regional Medical Center*

*Family Practice Conference, first & fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center*

*Geriatrics Conference, third Friday, 12:00 noon, Jefferson Regional Medical Center*

*Internal Medicine Conference, second & fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center*

*Obstetrics/Gynecology Conference, second Tuesday, 12:00 noon, Jefferson Regional Medical Center*

*Orthopedic Case Conference, second & fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.*

*Pediatric Conference, third Wednesday, 12:00 noon, Jefferson Regional Medical Center*

*Radiology Conference, third Tuesday, 12:00 noon, Jefferson Regional Medical Center*

*Southeast Arkansas Medical Lecture Series, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.*

*Surgery Conference, first Friday, 12:00 noon, Jefferson Regional Medical Center*

*Tumor Conference, first Wednesday, 12:00 noon, Jefferson Regional Medical Center*

### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center*

*Chest Conference, third Wednesday, 12:30 p.m., St. Michael Hospital.*

*Internal Medicine Conference, second Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center*

*Neuro-Radiology Conference, first & third Thursday, 7:00 a.m. breakfast, Wadley Regional Medical Center*

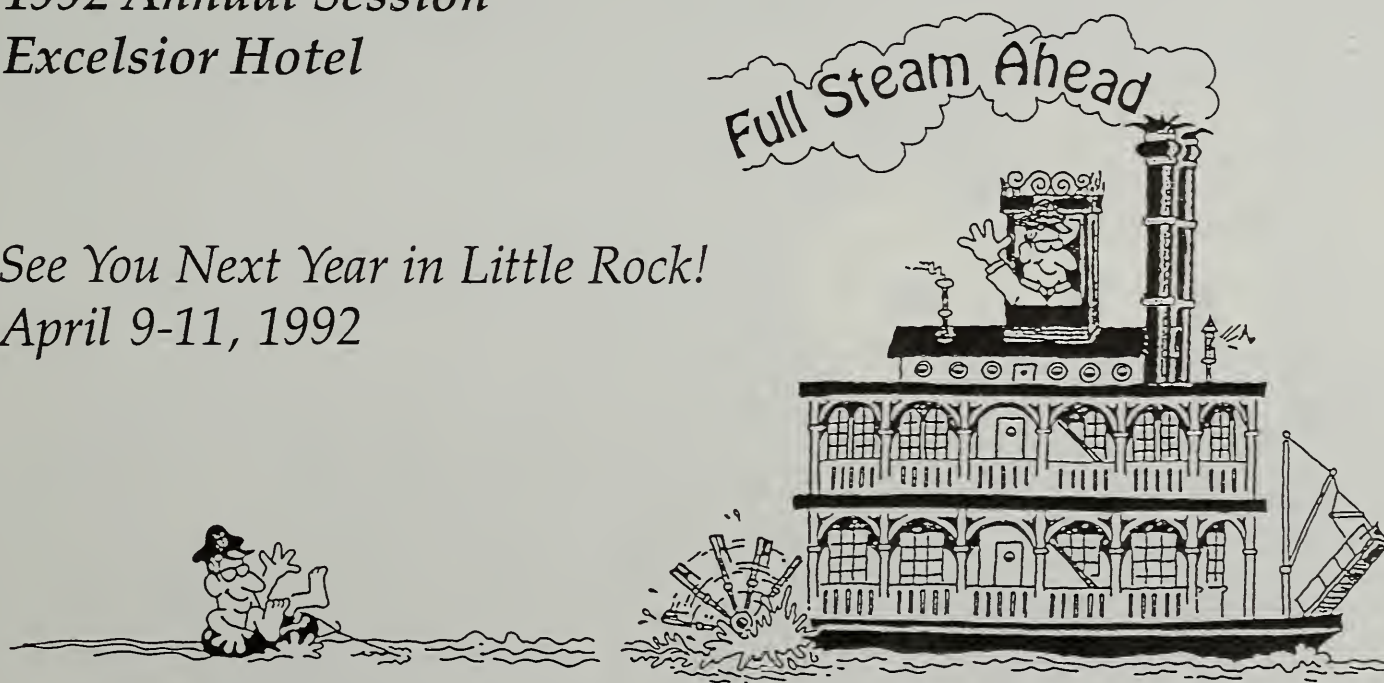
*Surgeons Pathology Conference, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center*

*Tumor Conference, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital*

*AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital*

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Arkansas Express Claims .....	67
Bentonville Medical Clinic .....	47
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Collom & Carney Clinic Association .....	1
CompuMedics, Inc. ....	47
Eli Lilly & Company .....	11
<i>Garrison, Jasper, Rose &amp; Company</i>	
Glaxo Pharmaceuticals .....	69
Tommy Farrell Associates .....	72
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	73
I Care of Arkansas .....	back cover
Medical Doctors & Health Services .....	1
Medical Protective Company .....	23
<i>Ferguson Advertising, Inc.</i>	
Medical Protective Company .....	43
Medx .....	35
National Library of Medicine .....	65
Ponderosa Properties .....	33
Radiology Consultants .....	4
Rather, Beyer & Harper .....	59
State Volunteer Mutual Insurance Company .....	2
<i>The Maryland Group</i>	
U.S. Air Force .....	37
<i>Bozell, Inc.</i>	
University Cardiothoracic Surgery .....	1

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## MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" floppy diskette containing the manuscript. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

## REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

## ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

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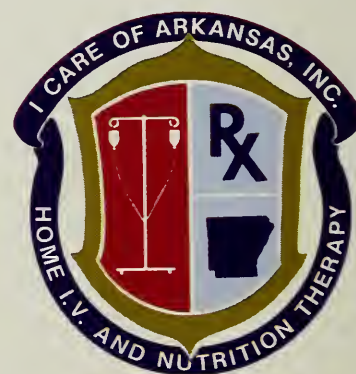
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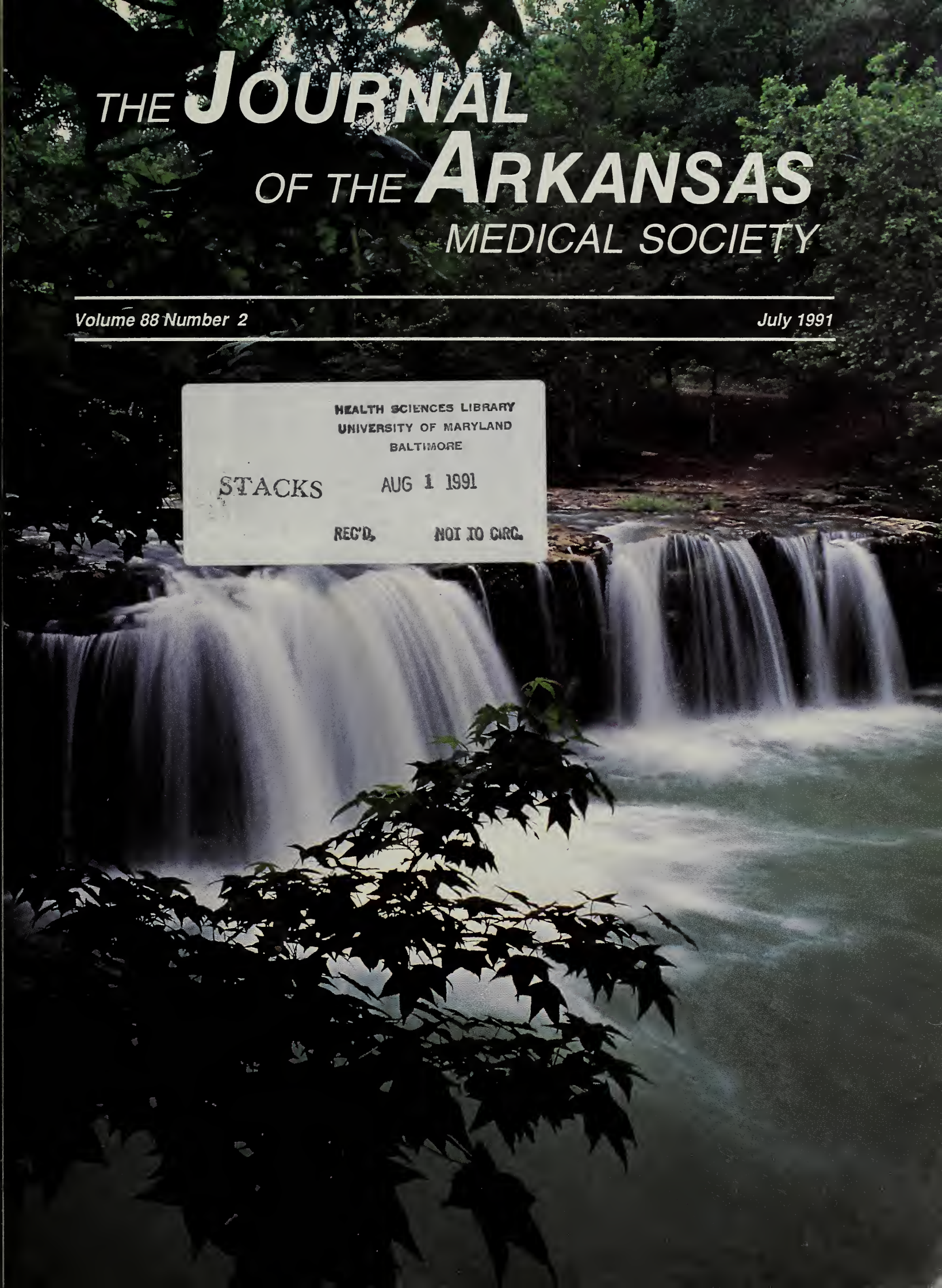
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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 2

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## CONTENTS

### FEATURES

- |    |  |
|----|--|
| 80 | Ready or Not, Here They (Eventually) Come:<br>Medical Practice Guidelines<br><i>Editorial</i><br>Lee Abel, M.D.  |
| 83 | Laparoscopic Laser Cholecystectomy<br>J. Michael Stair, M.D., John M. DeLoach Jr., M.D.,<br>Linda A. Woodward, R.N., Frank R. Ludwig, M.D.   |
| 86 | Coughing Up of Metastatic Tumor as the Initial<br>Clinical Manifestation of Renal Cell Carcinoma<br>Nanjunda S. Subramanyam, M.D., Herb Fendley, M.D.,<br>William H. Freeman, M.D. |
| 89 | Physician Medical Records-Patient Access Revisited<br><i>Legally Speaking</i><br>Michael W. Mitchell, J.D.   |
| 92 | Come to My Office in the Morning<br><i>Loss Prevention Case Study</i><br>J. Kelley Avery, M.D.   |
| 94 | HIV: Risks to Health Care Workers and<br>Risk Reduction<br>Julie L. Gerberding, M.D., M.P.H.   |

### DEPARTMENTS

- |     |                                |
|-----|--------------------------------|
| 95  | AIDS in Arkansas Statistics    |
| 100 | AMS Newsmakers                 |
| 102 | New Members                    |
| 105 | Radiological Case of the Month |
| 108 | In Memoriam                    |
| 110 | Medicine in the News           |
| 112 | ECG of the Month               |
| 114 | Things to Come                 |
| 116 | Keeping Up                     |

Cover photo by A.C. Haralson of the Arkansas Department of Parks & Tourism.



# Ready or Not, Here They (Eventually) Come: Medical Practice Guidelines

Lee Abel, M.D.\*

Medical practice guidelines are a very hot topic being enthusiastically developed by a variety of groups. These groups include the AMA, multiple specialty and sub-specialty societies, HMO's, the RAND organization, insurers such as Blue Cross and Blue Shield, and other health care groups such as the Institute of Medicine. Indeed, the development of medical practice guidelines has been mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA 1989) which established a new agency in the Public Health Service, the Agency for Health Care Policy and Research. This agency has been given the responsibility to develop medical practice guidelines. Release of the first set of guidelines (on urinary incontinence, benign prostatic hypertrophy, and surgical pain management) is already past due as of January 1, 1991. Much to the dismay of a Congress impatient to have the guidelines released, these first three guidelines will not be released before the fall of this year. It is obviously much easier to mandate that practice guidelines be written, than to actually write such guidelines. Congress also required an evaluation of the impact of these initial three guidelines by January 1, 1993, and this, too, no doubt will prove to be an unrealistic deadline.

The reason for all of this intense interest in medical practice guidelines is the widespread acknowledgement of problems with our current health system. Some of the groups developing guidelines are concerned with standardization of medical care and are exasperated by the wide regional variations in utilization of certain diagnostic and treatment techniques. This naturally leads to questions as to who is over utilizing procedures and who is under utilizing procedures, or, as it has been phrased, "which rate is right?"<sup>1</sup> Other groups who are developing guidelines may focus on the steadily rising costs of American medical care and look to medical practice guidelines to stabilize and reduce costs. Other groups hope their guidelines will improve the general

quality of care and lead to less medical malpractice. These guidelines are obviously intended for physicians' use and some groups hope they will prove useful for patients as well. It is also evident that health insurers and malpractice lawyers may seek to use medical practice guidelines for their purposes.

Exactly what constitutes medical practice guidelines is not universally agreed upon. Much of what we learn in medical school, residencies, and practice is, of course, "practice guidelines." Much of this is a general approach type of knowledge that doesn't lend itself to diagrams and flow charts. Some of our knowledge, though, is in the form of specific algorithms as well as simple aphorisms (fever + heart murmur = blood cultures). Medical textbooks may vary in their guidelines, according to the particular philosophy of the writer, and may advocate extensive and specific guidelines, or may offer a more minimalist approach. Medical organizations for years have issued position papers on specific practice issues. One of the oldest and best known practice guidelines are those of the American Cancer Society for the detection of cancer in asymptomatic individuals.

The current push for medical practice guidelines involves a much broader approach than what we have seen so far. Similar to the notion that "war is too important to be left to the generals," the issues of medical practice have such a wide ranging impact on society, that it is felt a larger perspective than that offered by the medical community itself is needed. For example, medical experts in the specialty and sub-specialty societies may be seen as having a vested interest in a low threshold for performing procedures done by their members and on other such issues of "turf protection." Likewise, individual writers in the textbooks may have an idiosyncratic view of the importance of extensive workups in the disease of their expertise. In addition, single issue groups such as the American Cancer Society have a narrow goal (ie, prevention of cancer) that does not take into account other competing goals and values held by society. Thus, the panels that develop these medical practice guide-

---

\* Dr. Abel specializes in internal medicine and is affiliated with the Little Rock Diagnostic Clinic.



lines typically include non-physicians. For example, statisticians, business leaders, health insurers, lawyers, ethicists, and patients may all have valuable perspectives to contribute.

The difficult issue is not really the composition of the committee that will write the medical practice guidelines, but what criteria they will use to make their recommendations. Questions about the guidelines will abound. Will the guidelines be written in general terms to allow flexibility, or will they be written with specific terminology in an attempt to offer concrete help to patients and physicians? Will the guidelines take into account urban vs rural practice settings? The panel that writes one guideline may focus too narrowly on that issue and miss the general context as the American Cancer Society has been accused of doing. How will small but real benefits be weighed against large relative costs? The natural tension between lowering costs and providing quality care will make many of these guidelines, by necessity, subjective. It is quite easy to imagine scenarios where medical practice guidelines will in fact lead to higher, not lower costs. For example, despite the American Cancer Society Guidelines, most American women in the appropriate age groups are not receiving regular mammograms. If new guidelines on this issue succeeded in improving compliance by physicians and patients, the overall health of American women may well improve but costs may increase. A

woman who has her life saved at age 65 by the detection of a curable cancer, could live to age 90 and incur huge health care costs because of numerous unrelated medical problems. Using this logic, it would have been much "cheaper" for society if she had died of breast cancer at age 66.

It is unrealistic to expect that guidelines will be easily arrived at, or will achieve complete consensus. Doctors Fletcher and Fletcher in the *Annals of Internal Medicine* argue that the debate provoked by the medical practice guidelines will be healthy for medicine.<sup>2</sup> The issue for the individual practitioner will often be whether the guidelines make practice easier or more difficult. It's possible, of course, that the guidelines will be so controversial or so bland, that they will have very little effect on medical practice. Whether they turn out to be a part of the solution, or a part of the problem, or largely irrelevant, the pressures that are encouraging their development will insure that medical practice guidelines will continue to be discussed and debated for years to come. For the present, cautious optimism that practice guidelines may serve a useful part of future medical practice seems a reasonable attitude.

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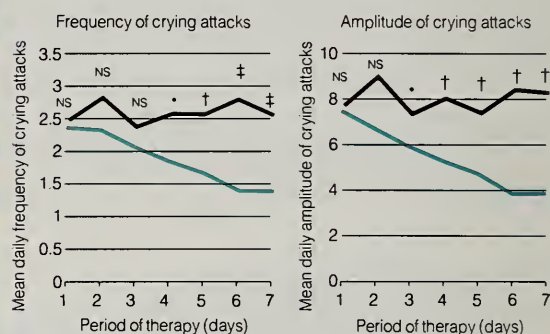
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# Laparoscopic Laser Cholecystectomy

## Results of 100 Successful Operations

J. Michael Stair, M.D.\*

John M. DeLoach Jr., M.D.\*

Linda A. Woodward, R.N.\*\*

Frank R. Ludwig, M.D.\*\*\*

### Introduction

Surgery continues to be the mainstay of therapy for symptomatic gallbladder disease. Non-operative measures for stone dissolution, such as lithotripsy and oral medications are of limited applicability due to narrow patient selection, high cost and possible long-term risks. Also, since non-operative measures leave the gallbladder in-situ, the underlying pathophysiology remains uncorrected and, hence, recurrence of stones is highly probable. Until an alternative therapy is developed which is as safe, as curative, and is cheaper than surgery, operative removal of the gallbladder will remain the "gold standard" of the treatment of biliary lithiasis.

Surgical removal of the gallbladder can now be accomplished by one of three methods. Standard cholecystectomy is usually performed by midline, subcostal or paramedian celiotomy. Additionally, cholecystectomy may be performed via a "mini-lap" transverse incision which does not cut muscle. Alternative to these operative approaches is laparoscopic laser cholecystectomy (LLC). Disadvantages of standard cholecystectomy are incisional pain and hospitalization averaging four to eight days. Although the mini-lap cholecystectomy is associated with less pain and hospitalization, recovery time and delay to return to work are still significant.

Advantages of laparoscopic laser cholecystectomy include superior visualization (especially as compared to mini-lap surgery), minimal trauma and pain, lower cost due to a shorter hospital stay, and earlier return to full daily activi-

ties.<sup>1-6</sup> Lower morbidity due to early mobilization and the almost non-existent risk of incisional hernia are additional positive features. The focus of this article is on the operative technique and our early results of laparoscopic laser cholecystectomy (LLC).

### Technique

Patient selection for LLC is made pre-operatively and will be discussed later. After induction of general endotracheal anesthesia, a nasogastric tube and Foley bladder catheter are placed to prevent inadvertent damage to stomach or bladder and to prevent gastric dilatation during the procedure. Additionally, nitrous oxide is avoided to prevent gastrointestinal distention.

A small infraumbilical incision is made and a Verres needle is placed to allow for pneumoperitoneum, as is standard in all laparoscopic procedures. A 10mm Surgiport (Auto Suture, U.S. Surgical Corp.) is then placed through the incision and the laparoscope with attached video camera is guided through the port. Two video monitors are essential to allow the operating and assisting surgeon to view proceedings.

A second 10mm Surgiport is placed two finger-breadths below the right costal border, approximately one centimeter to the right of the midline while viewing the peritoneal entrance via the video monitor. This port is the "working" port through which the dissecting tools, laser wand, suction apparatus, and hemoclip appliers are used. Two 5mm ports are then placed in the right flank through which the forceps which grasp and expose the gallbladder are placed.

After grasping the gallbladder with forceps and the cystic duct is placed on tension, dissecting tools are used to clear the cystic duct. At this point, a cholangiogram is done if indicated (indications are discussed later). After cholangiography, or if cholangiogram is not performed, the cystic

---

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duct is doubly hemoclipped and then divided with scissors. The cystic artery is handled in a like fashion. Preparation is made at this time to dissect the gallbladder from the liver bed. Irrigation with heparin solution at this time is recommended to prevent clotting of pooled blood.

The laser is used for gallbladder dissection. Our preference is for the contact tip YAG laser (Surgical Laser Technologies, SLT). This is precise and hemostatic. Once cholecystectomy is achieved, the gallbladder is actually removed via the umbilical port incision after the video camera and laparoscope have been repositioned in the upper 10mm "working" port. If removal is difficult due to large stones, the stones are morcellated with clamps placed into the gallbladder at the level of the umbilicus. Pneumoperitoneum is then released and all ports removed. All incisions are closed with steri-strips. The nasogastric tube and Foley catheter are removed prior to emergence from anesthesia.

## Results

Laparoscopic laser cholecystectomy has been attempted in 105 patients at Baptist Memorial Medical Center in North Little Rock, Arkansas. Successful LLC was performed in 100 patients. The average operative time has been one hour and 35 minutes (range from 40 minutes to three hours and five minutes). However, the average operative time for the last 40 cases was one hour and 15 minutes, reflecting increasing experience and facility with the technique. Patient age ranged from 19 to 83 years. Most patients had an overnight stay in the hospital. A few patients have stayed longer and six patients have been done as outpatients. The average length of stay was 1.4 days. However, many patients stayed due to fear of going home too early, more than of medical necessity.

There were four major complications. One patient developed a partial small bowel obstruction which cleared without surgery. The bowel obstruction was not felt to be related to the procedure. Another patient developed bilateral pneumonia 10 days post-operatively, requiring rehospitalization. One patient required a two-unit transfusion post-operatively and had no further problems. This most likely was due to oozing from the gallbladder bed and was early in our experience. One patient required laparotomy on post-operative day seven due to bile leakage from the gallbladder bed.

Minor complications included one urinary tract infection due to catheterization and a case of mild pancreatitis. Both of these complications were treated without hospitalization. Most patients will run a low-grade fever post-operatively due to atelectasis, secondary to general anesthesia and pneumoperitoneum. Atelectasis is expected and we do not consider this a complication.

Stones have been lost in the abdomen in less than 10% of patients. Since retrieval was impossible without laparotomy, stones were left in-situ without sequelae or consequence. Drainage is not routinely employed, although it is easy to do.

Five patients were opened and laparoscopic technique

was abandoned. Three patients had extremely acute gallbladder disease in which the procedure was abandoned due to difficulty grasping the gallbladder and one of those patients also had choledocholithiasis. Two patients had common bile duct stones demonstrated on operative cholangiogram and underwent open exploration of the common bile duct.

## Discussion

Laparoscopic laser cholecystectomy is an acceptable procedure in most patients with symptomatic gallbladder disease. Patients with common bile duct stones, however, present a more problematic situation since the technology is not yet available for laparoscopic common bile duct exploration. If common bile duct stones are suspected pre-operative by liver function tests or history, endoscopic retrograde cholangiopancreatography (ERCP) can be performed to prove or disprove choledocholithiasis. If stones are present in the duct, these frequently can be cleared with endoscopic sphincterotomy. If stones are cleared, LLC can then be performed safely. If stones remain, consideration should be given for more conventional open procedures.

Many, but certainly less than half, of our patients underwent operative cholangiogram. Cholangiography as a routine has not been shown to be cost effective or necessary.<sup>7</sup> Currently, our indications for operative cholangiogram are: abnormal liver function tests suggesting choledocholithiasis, prior history of jaundice or pancreatitis, multiple small stones with a patulous cystic duct, or enlarged common bile duct. Obviously, the patient who presents with cholangitis is not an optimal candidate for LLC. These patients may require ERCP pre-operatively, or merely be considered for an open procedure. Currently, we do not feel that operative cholangiogram is mandatory and we feel this portion of the procedure should be individualized in keeping with the above accepted criteria.

Contraindications to the LLC include multiple upper abdominal operations precluding safe laparoscopic technique. We have done numerous procedures in people who have had appendectomy, multiple pelvic procedures, and even right nephrectomy. Severe, concurrent medical problems are not contraindication to LLC and, in fact, may be an indication for this procedure when open technique would be hazardous. Need for common bile duct exploration likewise is a relative contraindication to laparoscopic technique.

## Summary

It would seem that laparoscopic laser cholecystectomy is a safe and reasonable procedure. We feel that it will be indicated for most patients with symptomatic gallbladder disease. The only distinct contraindications which we have noted are multiple prior upper abdominal procedures, common bile duct obstruction, or intense acute inflammation. However, as experience has widened, even some of the above problems may be manageable with laparoscopic technique. We would expect that the technique can be attempted

on at least 90% of patients with proven gallbladder disease and that this percentage may increase with further experience.

Our experience suggests that there is probably no increased operative risk with this operation. Any potential risks associated with pneumoperitoneum and introduction of laparoscopic instruments is more than offset by higher morbidity associated with open techniques. Besides the obvious economic benefits of shorter hospital stay and recovery time and rapid return to self-care and employment, this operation is quite rewarding for both surgeon and patient due to the decrease in post-operative pain and discomfort and a striking decrease in pulmonary problems, phlebitis and other complications of more invasive procedures. We expect this to become the standard procedure for gallbladder disease as experience is widened.

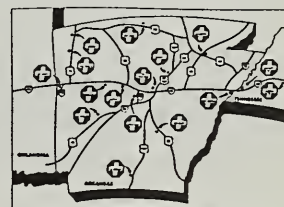
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# Coughing Up of Metastatic Tumor as the Initial Clinical Manifestation of Renal Cell Carcinoma

Nanjunda S. Subramanyam, M.D.\*

Herb Fendley, M.D.\*\*

William H. Freeman, M.D.\*\*

*ABSTRACT: A 48 year old white male presented to our office with a piece of tissue which he had coughed up earlier. Histopathology proved it to be a clear cell carcinoma. Bronchoscopy demonstrated the stump of a lesion in the distal trachea. Renal arteriogram confirmed a large renal cell carcinoma of the upper pole of the right kidney.*

## Case Report

A 48 year old white male presented to the Family Practice Center in Pine Bluff stating he had coughed up a piece of tissue followed by slight hemoptysis earlier that same day. He had the fragment wrapped in tissue in his hand. Prior to this episode, he had some respiratory difficulty with mild wheezing for a short period of time, all of which were relieved by the above event. Otherwise, he was asymptomatic. The specimen presented was a solid yellow-gray nodule measuring 1.5 x 1.5 x 1 centimeter. It was placed in fixative and submitted for histopathology.

Past medical history revealed that this patient had been followed in our office for moderate to severe hypertension which had been adequately controlled with an angiotensin-converting enzyme inhibitor and diuretic. All previous laboratory data including urine analysis and routine blood chemistries and blood counts had been without evidence of hematuria or renal dysfunction. He did have a 20-25 pack/year history of smoking, but had quit approximately 6 years ago. He gave no history of gross hematuria or flank pain with this episode or previous to it.

Physical exam on presentation revealed an obese white male in no distress. He was afebrile and his blood pressure was 154/80. HEENT exam was negative. The neck was supple without adenopathy. No supraclavicular nodes were palpable. Heart exam revealed a non-pathologic grade I/IV systolic murmur at the lower left sternal border. The chest was symmetric to inspection and clear to auscultation and percussion. The abdomen was obese but revealed no organomegaly or other mass, and no bruits were auscultated. Genital/urinary exam was normal, as was the rectal exam. Stool guaiac was negative. Examination of the extremities revealed trace pretibial edema with no clubbing or cyanosis. Neurological exam was negative.

Histopathology of the specimen surprisingly revealed a clear cell carcinoma (photo 1). Subsequent laboratory evaluation was extensive. SMA, lytes, CBC and urine analysis were all negative, as were PA/Lat chest ex-ray, bone scan and CT scan of the chest. IVP and CT of the abdomen revealed

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a mass over the upper pole of the right kidney. Renal arteriogram was consistent with a large renal cell carcinoma (photo 2). Laryngoscopy was negative and bronchoscopy revealed a vascular polypoid lesion in the distal trachea about 3 cm above the carina thought to be the stump of the main metastatic lesion. The biopsy of this site only revealed squamous metaplasia without evidence of malignancy. No other lesions were found.



Photo 1



Photo 2



Photo 3

The patient was then taken to surgery where a transabdominal radical nephrectomy with adrenalectomy and regional lymphadenectomy were performed. There was no detectable intra-abdominal metastasis. Histopathology of the surgical specimen (photo 3) showed a grade II renal cell carcinoma with involvement of the renal capsule. All nodes were negative.

The patient's postoperative recovery was uneventful and he was discharged from the hospital in good condition. He has been followed closely over the past 18 months without further evidence of metastasis.

## Discussion

Renal cell carcinoma typically presents with hematuria and/or a palpable mass in the flank. It is also well-known for its extra-renal manifestations. Unusual initial extra-renal presentations such as rectal bleeding<sup>1</sup> and recurrent epistaxis<sup>2</sup> have been reported. To our knowledge, this is the first reported case of renal cell carcinoma presenting as a coughed-up metastatic mass as the initial manifestation.

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# Physician Medical Records Patient Access Revisited



Michael W. Mitchell, J.D.\*

Physician inquiries continue about patient access to medical records. Much of this article is a reprint of the December 1987 article on the same subject. However, coverage is given to the new medical records law passed by the Arkansas Legislature.

The historical approach to patient access to physician medical records has been physician control as to "what information is given to the patient, for the patient's own good."<sup>1</sup> Justification for withholding records includes: lack of patient understanding due to technical language;<sup>2</sup> patient might misinterpret and possibly even indulge in self-medication;<sup>3</sup> adverse information in the medical record could be harmful to the patient;<sup>4</sup> record might reflect confidential statement by third persons.<sup>5</sup>

The recent trend has been toward direct patient access. The AMA takes the position that a copy or a summary of the records should be provided to the patient on request. Rule 7.02 provides:

Notes made in treating a patient are primarily for the physician's own use and constitute his personal property. However, **on request of the patient a physician should provide a copy or a summary of the record to the patient** or to another physician, an attorney or other person designated by the patient.<sup>6</sup>

The American Hospital Association also recognizes the patient's right to "complete and current information con-

cerning his diagnosis, treatment and prognosis in terms the patient can reasonably be expected to understand."<sup>7</sup>

Courts readily grant access to physician medical records since the patient "...clearly has an interest in certain information contained in the record."<sup>8</sup> In recognizing the fiduciary qualities of the physician-patient relationship, courts often place a duty on the physician "...to reveal to the patient that which, in his best interest, he should know..."<sup>9</sup> Another court, basing its decision on fiduciary principles stated:

It is our opinion that the fiducial qualities of the physician-patient relationship **require the disclosure** of medical data to the patient or his agent **on request** and that the patient need not engage in legal proceedings to attain a loftier status in his quest for information.<sup>10</sup>

In both *Emmett, supra*, and *Connell, supra*, the courts recognized hospital/physician ownership of the records and neither would require release of the information deemed medically harmful to the patient. However, where there is no statutory right to access, courts may deny patient request to inspect and copy where the interest is not deemed legitimate.<sup>11</sup> For example, a former mental patient was denied the right to copy her medical records to verify information desired for writing a book.<sup>12</sup> Therefore, where there is no statutory right of access, the patient has no absolute right but must show a legitimate interest to require disclosure.

Many states have by legislation granted the patient the direct right of access to the medical records.<sup>13</sup> In the 1991 session of the Arkansas General Assembly, legislation was passed dealing with medical records. Act 767 of 1991 pertains to requests by the patient or the patient's attorney for

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medical records "in contemplation of, preparation for or use in any legal proceeding." Act 767 grants authority to the patient or his or her attorney to obtain copies of medical records on request for a specified fee. **Copy charges may not exceed \$1 per page for the first five pages and 25 cents for each additional page except that a minimum charge shall be \$5.** The physician may charge, however, a reasonable fee for narrative medical reports or medical reviews performed by the doctor. A therapeutic privilege exception is provided in Act 767 when the doctor feels the patient should be denied access to his or her medical records. The physician is required to tell the patient in writing that disclosure of such information would be "detrimental to the individual's health or well-being." The patient then may select a second physician in the same type practice to render a second opinion. If the second physician agrees, the records will either not be released or the objectionable material will be "obscured" before release. If the second physician disagrees the medical records "shall be released." Thus, for the first time in Arkansas history, legislation prescribes patient access to medical records.

In the age where paternalistic attitudes such as concealing diagnosis from patients "for their own good" are giving way to patient autonomy, the traditional reasons for withholding medical records appear to be in serious erosion.<sup>14</sup> Some take the position that reviewing one's medical records has a positive effect on the physician-patient relationship.<sup>15</sup> Some physicians believe it is therapeutic for the patient to read their own records to increase understanding and reduce anxiety.<sup>16</sup> The fiduciary responsibility of the physician as well as the patient's need to make final arrangement are arguments for disclosure or limited disclosure of even the worst diagnosis. Where physicians consider "record-sharing" part of the patient treatment, they report better patient participation in their own care, medical records in plain language and fewer errors.<sup>17</sup> "Record-sharing" is not without its problems, however, (e.g. patient anger due to adverse comment; patient request to omit embarrassing information; disagreement by patient of diagnosis; disclosure of third party information).<sup>18</sup>

Whether it is the better procedure to withhold medical records or disclose medical records is still being debated by practicing physicians. However, it is certain that the trend of judge-made laws and legislator-made laws is toward disclosure. The modern view is one toward more patient autonomy. In the event physicians cling to the old ways of the past, we are likely to see more and more legislative action as well as court action to enforce the perceived rights of patients for disclosure of their medical records. Furthermore, patient relations seem to be fostered by a cooperative willingness to supply information. There is a little doubt that a patient "...who has to pay a lawyer to find out about his health status won't want to see the particular doctor again—unless it's in court."<sup>19</sup>

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1. 34 Buffalo L. Rev. 317, 324 (1974).
2. Id. 324.
3. Id. 324.
4. Id. 325.
5. Id. 326. Also see: "What Happens When Patients See Their Charts" Medical Economics, p. 108 (Sept. 7, 1987).
6. Current Opinions of the Judicial Council of the American Medical Association, 7.02.
7. American Hospital Association, "The Patient's Bill of Rights" § .02.
8. "The Patient's Right To Access To His Hospital and Medical Records," Medical Trial Technique Quarterly, 295, 299 (1978).
9. Emmett v. Eastern Dispensary & Casualty Hospital, 396 F.2d 931 (D.C. 1967).
10. Connell v. Medical & Surgical Clinic, 21 Ill. App. 3d 383, 315 N.E. 2d 278 (1974).
11. The Patient's Right to Access to His Hospital and Medical Records, Medical Trial Technique Quarterly, p. 308 (1978).
12. Gotkin v. Miller, 379 F. Supp 859 (1974).
13. Supra, note 11.
14. Clinical Ethics, (2d ed.) § 2.0 (MacMillan, 1986).
15. 34 Buffalo L. Rev. 317, 325.
16. Medical Economics p.93 (Sept. 7, 1987).
17. Id.
18. Id. p. 94, 100, 106, 108.
19. Supra, note 16, p. 106.



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## Come to my Office in the Morning

J. Kelley Avery, M.D.\*

With very few exceptions every physician who reads this column will have made that statement many times during the course of her practice. Most of the time such a statement is entirely justified and is extremely good advice. However, an event occurs once in a while, to make us realize that "come to my office in the morning" is a piece of advice that must be given due regard for the circumstances involved in that particular case.

### Loss Prevention Case

A 58-year-old male had been treated in the hospital for an acute myocardial infarction which was complicated by severe, persistent pain and some congestive heart failure. His initial period of hospitalization was something slightly less than two weeks. He became pain free after four or five days in the hospital, and although he developed significant pulmonary congestion, on proper diuretics and low-salt intake, his lungs cleared and at the time of discharge, he was pain free and breathing easily.

On leaving the hospital, he was given instructions about medications which included nitroglycerine and diuretic to be taken daily. A graduated program of exercise was prescribed and he was given an appointment to see his cardiologist two weeks from the time of discharge.

During the six days following discharge, there were four telephone calls from the patient, each time complaining of chest pain. Each time he called he talked to a resident who had seen him while he was in the hospital. He was advised to take his nitroglycerine regularly, was reassured, and reminded of his appointment with the cardiologist. Nine days after discharge, on a very busy night in the ER, he appeared at 3:00 a.m. with severe chest pain, marked diaphoresis and extreme shortness of breath. The hospital was very crowded and there were no available beds in the coronary care unit. He was observed for about 6 hours in the ER and given morphine, IV diuretics, and oxygen support with marked improvement. His chest pain subsided and with oxygen he was no longer short of breath. After the period of observation, he was allowed to go home and was told to "see his cardiologist in the morning." He returned to the ER two hours later in severe congestive heart failure, experienced

cardiopulmonary arrest in the ER and died two days later.

After a lawsuit was filed in this case, the investigation revealed that this patient's four calls to his cardiologist had been handled by two different residents. Although they communicated with the cardiologist, there was no effort on their part or the part of the specialist to have the patient speak with the cardiologist himself. It was learned on investigation that on the night when the patient went to the ER with chest pain and shortness of breath, the cardiologist approved by telephone the resident's decision to allow the patient to go home after the six hour period during which he responded to treatment. The litigation resulted in a large settlement.

### Loss Prevention Comments

The lawsuit charged the residents and the cardiologist with negligence in the care of the patient. One of the most damaging facts uncovered in the investigation and one, among others, that lead to the large settlement, was the fact that the "crowded hospital" somehow influenced the decision by the resident and the cardiologist to allow this man to return to his home rather than keep him in the hospital.

Conditions other than those presented by the patient frequently influenced our decisions relative to the patient's care. In this very tragic case, it was a "crowded hospital," "the unavailability of a bed in the CCU," and a genuine feeling that the patient would be better off at home than he would have been in an unmonitored bed on a regular medical floor that lead to his being allowed to return home. Sometimes, when there are no financial impediments to the care of patients, we might do things differently than we would if the patient were going to be unable to pay his hospital bill. When we practice in an area remote from a tertiary care hospital, we might well "wait" for a patient to stabilize when, given the same patient in a tertiary care setting, our management would be more aggressive. Within limits, these variations in our management of patients under differing circumstances can be fully justified. However, when a bad result occurs, which can be linked to decisions we make because of circumstances other than those inherent in the condition of the patient, we put ourselves in a position that sometimes is legally hard to defend if litigation results. In this case, it is entirely probable that the outcome for this patient would have been the same even if he had been retained in the hospital, but it could be argued the other way.

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\* Dr. Avery is the chairman of the Loss Prevention Committee at St. Volunteer Mutual Insurance Company and the medical director, Ambulatory Services, at St. Thomas Hospital in Nashville, Tennessee.



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## HIV: Risks to Health Care Workers and Risk Reduction

Julie L. Gerberding, M.D., M.P.H.\*

*The following is an outline of Dr. Gerberding's speech that she made to the attendees of the 4th Annual AIDS Seminar at the Arlington Hotel in Hot Springs, Arkansas. If you would like to hear her speech in its entirety, you may order an audio tape from the Arkansas Medical Society.*

### Objectives

1. To present the current epidemiologic evidence assessing risks to health care workers from occupational HIV exposure.
2. To describe current strategies for reducing risks to health care personnel.
3. To describe the current status of post-exposure HIV chemoprophylaxis.

### I. Risks to Health Care Workers (HCW)

#### A. Surveillance of AIDS in HCW

1. Approximately 68 no identified risk (NIR) cases of AIDS in HCW (1/91); epidemiologic evidence does not support occupational transmission as the major route of infection in this group (over-representation of non-clinical personnel with no history of exposure in geographic areas with low HIV prevalence); however occupational infection cannot be excluded with certainty in any of the NIR cases

#### B. Prospective Cohort Studies of HIV Infection in HCW Sustaining Discreet Exposures to HIV

1. More than 2000 HCW with intensive exposure (including 2008 needlestick exposures to infected blood prospectively) tested in the past four - five years
  - a. Measured risk from routine (non-parenteral) contact with infected patients = 0 (no infections in 4000 subjects)
  - b. Measured risk from splatter, splash and/or aerosolization = 0
  - c. Measured risk from mucous membrane/cutaneous contact via skin lesions = 0
  - d. Risk from a discreet needlestick exposure to infected blood = .31% (six infections after 2008 documented needlestick exposures to infected blood after > or = to six month follow-up)
  - e. Only needlesticks or similar percutaneous exposure to blood associated with infection in study subjects to date
  - f. Infectivity is likely to be dependent on titer of virus involved in exposure which in turn is dependent on volume of blood transmitted and degree of source patient viremia
  - g. Since titers in symptomatic carriers are one to three logs lower than titers in patients with severe HIV infection, exposures to source patients with early HIV disease may confer a risk significantly less than that associated with most of the exposures tracked in the above studies (which primarily involve hospitalized source patients with AIDS)

#### C. Case reports of HIV infection in HCW (thru 1/91)

1. Nineteen documented cases of occupational HIV transmission (documented seroconver-

\* Dr. Gerberding is assistant professor of the Department of Medicine at the University of California in San Francisco and director of HIV Prevention Service at San Francisco General Hospital.

sion - 18; virus isolate identity - 1) reported since 1981:

- 11 needlesticks (including 4 above)
- 1 laceration (blood)
- 4 mucocutaneous (blood)
- 1 cutaneous (?)
- 1 laceration (concentrated virus)
- 1 mucocutaneous (concentrated virus)
- (15 of these in U.S.)
- 2. Seven additional possible cases reported in medical literature (six needlesticks/one mucocutaneous); seroconversion not documented because baseline HIV test not performed
- 3. CDC reports eight additional seroconversions associated with needlestick injury and approximately 30 cases currently under investigation that may or may not represent occupational transmission. Details of these cases are not yet available for review
- D. Cumulative Professional Risk
  - 1. Cumulative risk dependent on:
    - a. frequency of exposure
    - b. severity of exposure
    - c. prevalence of HIV
  - 2. Cannot generalize data from risk estimates derived from hollow-bore needlestick exposures to exposures in other settings e.g. intraoperative needlesticks involving non-hollow needles contaminated with blood from source patients with early HIV infection passing through latex gloves. Therefore, modeling cumulative risk is difficult
  - 3. Data from U.S. Army Reserve health care personnel undergoing mandatory HIV testing suggests that employment as a physician (surgeon) or dentist is not associated with an increased risk of HIV compared to non-HCW
  - 4. More data and prolonged follow-up of high-risk personnel clearly needed
- E. Transmission of hepatitis and cytomegalovirus
  - 1. No excess risk of CMV from care of HIV-infected patients in two major prospective studies
  - 2. Hepatitis B virus most common serious occupational infection in HCW despite vaccine; > 200 deaths in HCW attributed to acute/chronic occupationally-acquired HBV each year
  - 3. Prevalence of hepatitis B increasing in U.S.
  - 4. Evidence mounting to document occupational risk from hepatitis C virus exposures

## II. HIV Transmission from HCW to Patient

- A. Recent reported case of AIDS associated with a tooth extraction performed by an infected dentist
  - 1. Route of transmission unknown:
    - a. contaminated instruments?
    - b. direct inoculation?
    - c. genetic sequencing of small components indicates that virus isolates from dentist and patient are probably epidemiologically linked
  - 2. Two other patients also HIV positive; as of 1/91, initial investigation indicates that their viral isolates are similar to dentist's isolates
- B. Retrospective reviews of more than 600 surgical patients operated on by infected surgeons reveal no cases of transmission. Two similar studies demonstrate similar findings
- C. Transmission possible under extraordinary circumstances (bleeding into a body cavity) but too low to be easily amenable to quantization or study
- D. Risk likely to be limited to a small number of procedures associated with HBV transmission, e.g. blind vaginal hysterectomy, certain orthopedic procedures, some oral surgical/dental procedures
- E. Public health concerns not likely to be a major determinant of subsequent policies; public opinion, politics, and profit appear to be strong influencers of reactions to this issue
- F. Costs of implementing mandatory HIV-testing of HCW and managing the consequences is expected to be enormous; \$800,000 annually is a low estimate for SFGH

## III. Risk Reduction: Assigning Infection Control Precautions

- A. Advantages of Universal Precautions/Body Substance Precautions:
  - 1. Uniform generic standard of infection control; simple to teach/learn
  - 2. Protects HCW from diagnosed and undiagnosed bloodborne infections
  - 3. Protects both HCW and patients; may decrease transmission of all nosocomial pathogens including bloodborne pathogens and bacteria
  - 4. No delays; effective from moment of initial contact with patient; practical in ER/OPD
  - 5. Minimizes risk to patients
  - 6. Consistent with CDC/OSHA Guidelines
- B. Disadvantages of Universal Precautions/BSP
  - 1. Represents significant change in infection control procedure; requires re-education
  - 2. Enforcement and monitoring of compliance may be necessary
  - 3. Increased expenditure for gloves, other protective equipment



4. If "overused," barriers may promote transmission of nosocomial pathogens among patients; (reported from at least one institution although others have seen a decline in nosocomial infections)
- C. Purported Advantages of HIV Testing for Infection Control
1. Decreased HIV transmission by
    - a. improved compliance with infection control precautions
    - b. assigning "special" infection-control precautions for patients labeled as infected
    - c. avoiding contact with (care of) infected patients
  2. Diagnosis of unsuspected infection in persons without obvious indications for voluntary screening -- early intervention
- D. Disadvantages of HIV Testing for Infection Control
1. No documentation of efficacy in reducing exposures by objective measurement in any study reported to date
  2. Expensive: Cost of performing screening/confirmatory tests; cost of counseling and follow-up
  3. False positives/false negatives
  4. Ethical considerations: confidentiality informed consent, false positive tests, who should pay for tests, adverse effects on medical care
  5. Practical considerations: what to do until results available in the ER, outpatient settings, pre-hospital care setting
  6. False sense of security: may increase transmission of other pathogens from patients not labeled as infected
  7. Psychosocial risks to patients: discrimination (housing, employment, insurance); medical discrimination (refusal to provide care, transfer to other facilities)

#### IV. Risk Reduction: New Devices and Technology

- A. Safer needles: simpler is better
1. Re-sheathing
  2. Retracting
  3. Needle guards
  4. Disposal systems
  5. Needlestick Model:
    - a. Gloving may reduce volume of blood transferred during a needlestick by more than 59%!
    - b. Volume of blood transferred is proportional to needle gauge, hollow vs. suture, and depth of penetration
- B. Barrier Protection
1. Waterproof materials
  2. Improved masks

3. Improved face shields
4. Durable gloves

#### V. Risk Reduction: Post-exposure prophylaxis for HIV

- A. Azidothymidine
1. 1-800 HIV-STIK Study (BW)
    - a. Randomized/double-blinded placebo controlled study
    - b. Discontinued due to low enrollment
  2. Efficacy
    - a. No convincing primate data to date.
    - b. Efficacy in feline/murine retrovirus models
    - c. Human data - difficult if not impossible to devise trial with sufficient power to prove efficacy
    - d. Three reports of prophylaxis failure
    - e. ? drug resistance when source patients on long-term therapy
  3. Toxicity
    - a. Short-term toxicity primarily hematologic (neutropenia/anemia); reversible
    - b. Rare with six weeks treatment especially in "healthy" patients
    - c. Long-term sequelae unknown.
    - d. Effect on fertility/spermatogenesis/ teratogenicity
  4. Current SFGH protocol: Zidovudine available on an experimental basis for exposed HCWs (this current protocol is identical to that used by the BW-sponsored multi-centered open trial of zidovudine toxicity in HCW in progress by investigators at UCSF/SFGH, NIH/CC, and CDC)

#### Questions

1. List three types of epidemiologic evidence used to assess the risk of occupational HIV infection.
2. What are the criteria for establishing occupational exposure as the mode of HIV infection?
3. What bloodborne infection currently incurs the greatest morbidity and mortality among health care personnel?
4. What is the major known toxicity of azidothymidine?

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## SFGH PROTOCOL FOR ADMINISTERING POST-EXPOSURE ZIDOVUDINE

First 2 Days:	200 mg q 4 h	(6 x / d)
Next 26 Days:	200 mg q 4 h	(5 x / d)
Massive Exposure	(Transfusion)	Recommended
Definite Parenteral	(IM/Injection)	Endorsed
Probable Parenteral (especially considered if Source Patient has AIDS or is likely to be highly viremic)	(SQ/Mucosal)	Available
Doubtful Parenteral	(Non-bloody)	Discouraged
Non-parenteral	(Cutaneous)	Not Provided

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### Family Practice Clinic

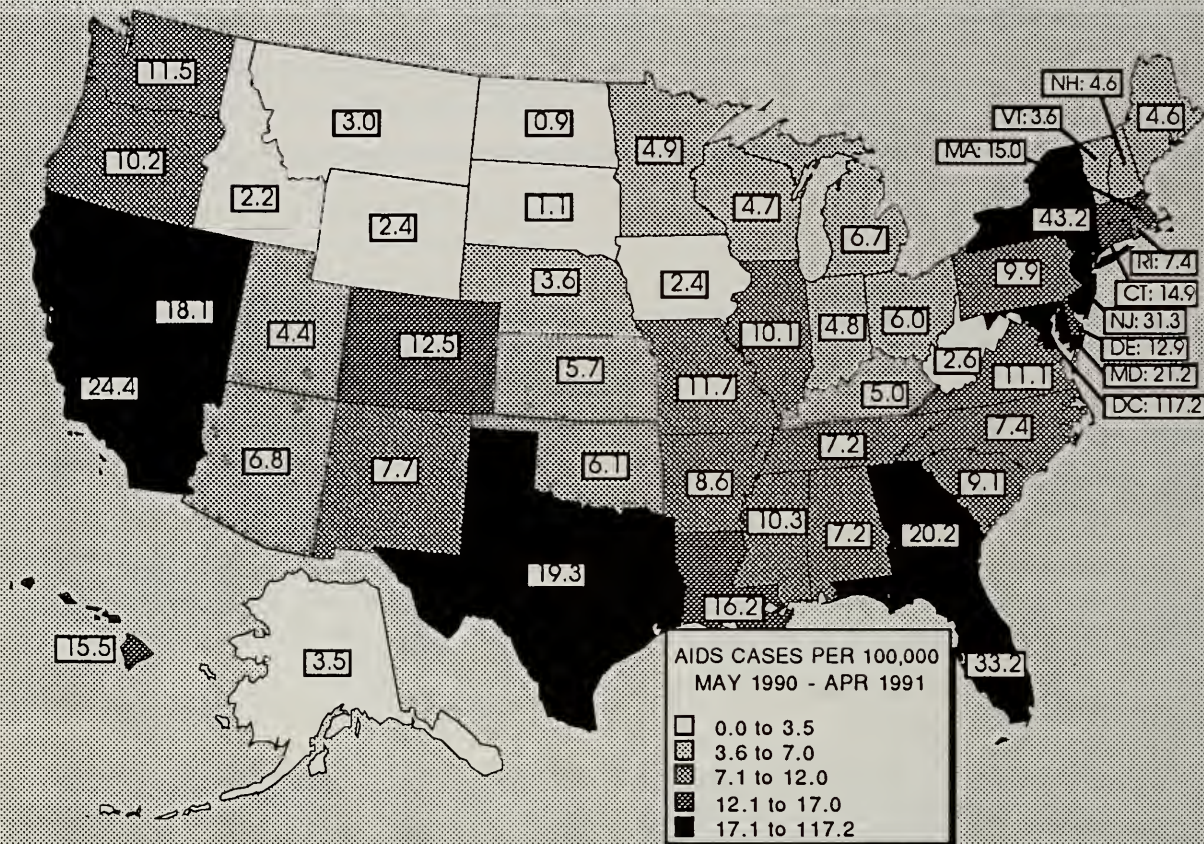
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# Arkansas HIV/AIDS Report 1983-1991

Arkansas Cases		United States Cases	
Reported: MAY '90 - APR '91	203	Reported: MAY '90 - APR '91	42,333
Rates per 100,000 population: APR '90 - MAR '91	8.6	Rates per 100,000 population: APR '90 - MAR '91	16.82
Cumulative Reports: 1983 - MAY '91	516	Cumulative Reports: 1980 - APR '91	174,893
Adult	503	Adult	171,865
Pediatric	13	Pediatric	3,028
Deaths: 1983 - MAY '91	299	Deaths: 1980 - APR '91	110,530
Adult	293	Adult	108,949
Pediatric	6	Pediatric	1,581
Mortality Rate	57.9%	Mortality Rate	63.2%



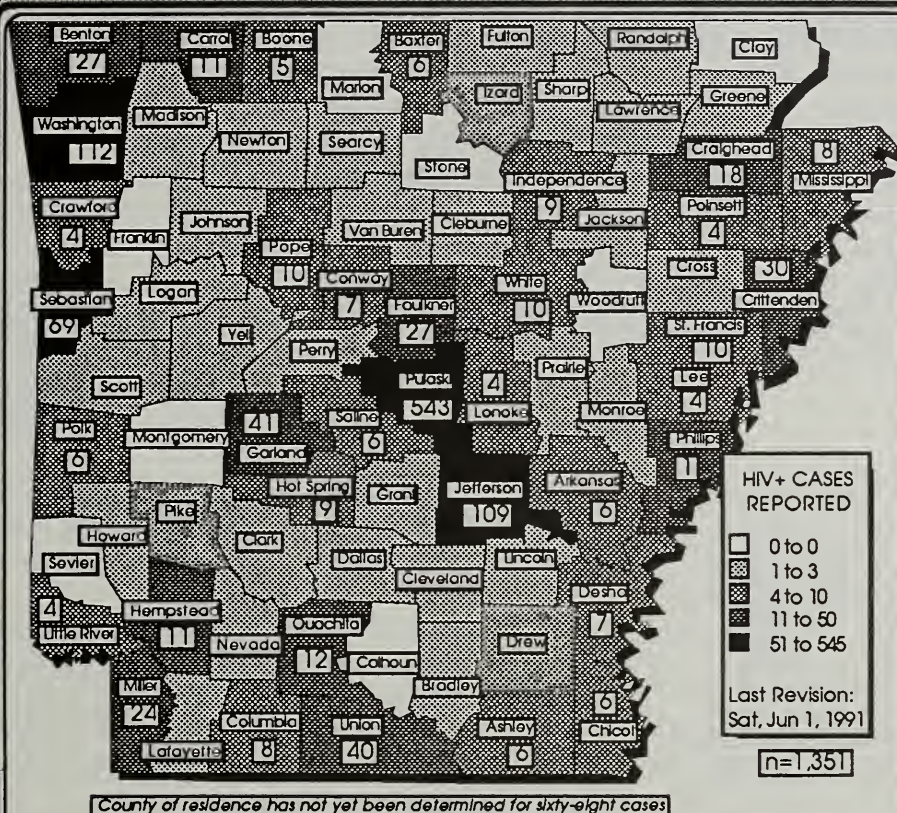
Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	63.3%	Gay or Bisexual Men	58.1%
Gay or Bisexual Men who used IV Drugs	9.7%	Gay or Bisexual Men who used IV Drugs	6.5%
Heterosexual IV Drug Users	10.7%	Heterosexual IV Drug Users	21.6%
Heterosexual contact with person at risk	5.0%	Heterosexual contact with person at risk	5.4%
Hemophilia	1.7%	Hemophilia	0.9%
Transfusion with blood products	3.9%	Transfusion with blood products	2.4%
Perinatal	1.9%	Perinatal	1.5%
Risk unknown at this time	3.7%	Risk unknown at this time	3.6%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

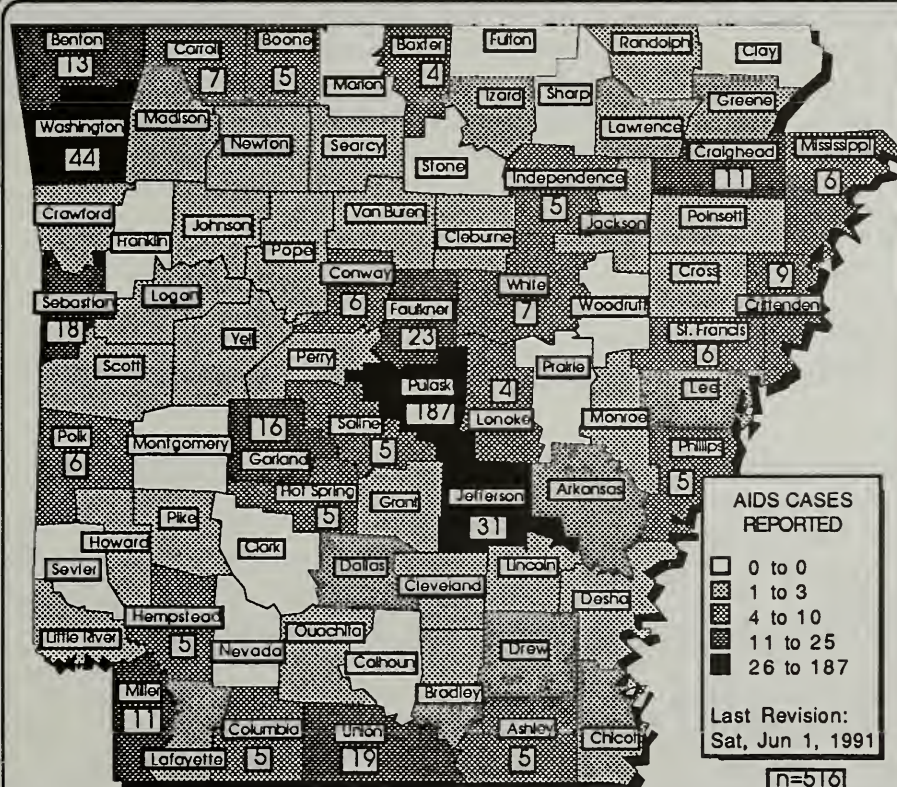


# Arkansas AIDS Report

## 1983-1991



County of residence has not yet been determined for sixty-eight cases



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statutes 20-15-904, 15-14-123, 16-82-101 and Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# AMS Newsmakers

---

**Dr. H.A. Ted Bailey Jr.**, a Little Rock physician and businessman was awarded an honorary Doctor of Humane Letters Degree by the University of Arkansas at Little Rock at their recent commencement exercises.

**Dr. Darrell Bonner**, of Paragould, has been elected to serve on the Arkansas Methodist Hospital board of directors.

**Dr. Steven Collier**, a family physician in Augusta, has been named medical director for Arkansas Operations of ABC Home Health of Arkansas.

**Dr. Asa A. Crow**, of Paragould, has been awarded the Dr. Tom T. Ross Award, the highest honor given by the Arkansas Public Health Association to someone employed outside of the state Department of Health. The award cites him for "outstanding service of the heart."

**Dr. Joycelyn Elders**, director of the Arkansas Health Department, was named the "Communicator of the Year" by the Arkansas Chapter of the International Association of Business Communicators.

**Dr. Morriss M. Henry**, a Fayetteville ophthalmologist, was recently elected to the University of Arkansas for Medical Sciences Foundation Fund board. Dr. Henry serves as a UAMS associate clinical professor of ophthalmology through the AHEC-NW in Fayetteville.

**Dr. Ted Honghiran**, a Russellville orthopaedic surgeon, was elected president of the Arkansas Orthopaedic Society recently.

**Dr. Sanford Hutson**, of Texarkana, has been named medical director of government programs services for Arkansas Blue Cross and Blue Shield.

**Dr. Sam Koenig**, a family physician in Fort Smith, has been appointed to the Technical Advisory Panel of Levine Associates Inc. of Kensington, MD. The panel will study the potential regulatory impacts of the Clinical Laboratory Improvement Amendments of 1988.

**Dr. Roger Lester** has been appointed to the Jerome S. Levy Chair of Gastroenterology at the University of Arkansas for Medical Sciences. Dr. Lester is a professor of medicine and director of the division of gastroenterology in the UAMS department of medicine.

**Levi Hospice** recently observed its 2nd anniversary. Levi Hospice offers a major alternative to traditional care for the terminally ill patient and their families. It is the only Medicare certified hospice in the Hot Springs area.

**Dr. Ben Saltzman**, medical director of the Pulaski County health unit in Little Rock, was honored recently by the University of Arkansas for Medical Sciences for his 13 years of service as director of the family practice intensive review course at the university. Dr. Saltzman was the first professor and chairman of the department of family and community medicine at UAMS, and he is now professor emeritus.

**Dr. Robert Shannon**, a Little Rock psychiatrist, has been named medical director with Professional Counseling Associates of Little Rock.

**Dr. Charles W. Smith Jr.**, medical director of the University Hospital of Arkansas, has been elected president of the American Board of Family Practice.

**Dr. Jacob M. Williams**, of Paragould, has been elected chairman of the Arkansas Methodist Hospital board of directors.

**Dr. Rhys Williams**, of Harrison, has retired after 32 years of service to the people of Harrison. He will continue to be involved in the field of medicine through his membership on the State Medical Board and the Arkansas Foundation for Medical Care.

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# New Members

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## CLEBURNE COUNTY

**Ferguson, John S.**, Dermatology/Laser Surgery, Heber Springs. Born July 12, 1929, Beebe. Medical education, UAMS, Little Rock, 1954. Internship/residency, U.S. Army, 1958. Practice experience, 30 years.

## CRAIGHEAD/POINSETT COUNTY

**Scroggin Jr., Carroll D.**, Hematology/Oncology, Jonesboro. Born January 30, 1956, Louisville, KY. Medical education, UAMS, Little Rock, 1978. Residency, University Hospital, Little Rock, 1988. Board certified.

## FAULKNER COUNTY

**Holland, Rhonda J.**, Emergency Medicine, Conway. Born January 6, 1956, Montrose, CO. Medical education, University of Oklahoma, Oklahoma City, 1982. Internship, Oklahoma Children's Memorial Hospital, 1983. Residency, University of Missouri, Columbia, 1989. Practice experience, 2 years. Board certified.

**Landberg, Karl H.**, Gastroenterology, Conway. Born May 13, 1955, Chicago, IL. Medical education, University of Chicago, 1980 and UAMS, 1986. Internship/residency, UAMS, 1989. Practice experience, 2 years. Board certified.

## GREENE/CLAY COUNTY

**Duplantis, Kathryn L.**, Dermatology, Paragould. Born May 7, 1953, Bryan, TX. Medical education, Medical College of Virginia, Richmond, 1979. Internship, Brooke Army Medical Center, 1980. Residency, University of Tennessee, Memphis, 1989. Board certified.

## INDEPENDENCE COUNTY

**Brown, Hunter L.**, Urology, Batesville. Born December 17, 1953, Magnolia. Medical education, UAMS, 1985. Internship/residency, UAMS, 1990. Pending certification.

## JEFFERSON COUNTY

**Fendly, Ann E.**, Internal Medicine, Pine Bluff. Born February 21, 1940, Providence, RI. Medical education, University of Oregon Medical School, Portland, 1971. Internship/residency, Los Angeles County, USC Medical Center, 1974. Practice experience, 7 years. Board certified.

## PULASKI COUNTY

**Beland, Susan S.**, Internal Medicine, Little Rock. Born July 27, 1946, E. St. Louis, IL. Medical education, UAMS, 1986. Internship/residency, UAMS, 1990. Board certified.

**Morrison, Lynn C.**, Pediatrics, Little Rock. Born April 22, 1959, Allentown, PA. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991.

## WHITE COUNTY

**Asmar, Salomon N.**, Internal Medicine, Searcy. Born January 1, Dominican Republic. Medical education, University of Puerto Rico, Rio Piedras, PR, 1977. Internship/residency, VA Hospital, San Juan, 1980. Practice experience, 7 years. Board certified.

## UNION COUNTY

**Bass, Edward J.**, Cardiology, El Dorado. Born November 7, 1946, Columbia, MS. Medical education, University of Mississippi, Jackson, 1976. Internship/residency, University Hospital, Jackson, MS, 1979. Practice experience, 11 years. Board certified.

**Sarnicki, Joseph D.**, Family Practice, El Dorado. Born January 21, 1952, Gary, IN. Medical education, University of Osteopathic Medicine & Surgery, Des Moines, IO, 1986. Internship, University of Illinois, 1987. Residency, AHEC South Arkansas, 1990. Practice experience, 1 year. Board certified.

## RESIDENT

**Anthony, John L.**, Dermatology. Born May 24, 1964, Fayetteville. Medical education, UAMS, 1991. Residency, UAMS.

**Collins, Douglas J.**, Pediatrics. Born January 8, 1964, West Memphis. Medical education, UAMS, 1991. Internship/residency, UAMS/Arkansas Children's Hospital.

**Houchin, Vonda G.**, Family Medicine. Born September 20, 1965, Walnut Ridge. Medical education, UAMS, 1991. Residency, AHEC-NE.

**Ruddell, Deanna N.**, Pediatrics. Born November 3, 1964, Newport. Medical education, UAMS, 1991. Residency, UAMS.

**Travis, Patrick M.**, Internal Medicine. Born November 18, 1963, Harrison. Medical education, UAMS, 1990. Internship/residency, UAMS.

**Waters, Samuel G.**, Orthopaedics. Born March 30, 1961, Magnolia. Medical education, UAMS, 1991. Residency, UAMS.

**Willadsen, Diana S.**, Internal Medicine. Born August 30, 1964, Kansas City, MO. Medical education, UAMS, 1989. Internship/residency, Madigan Army Medical Center, Ft. Lewis, WA.

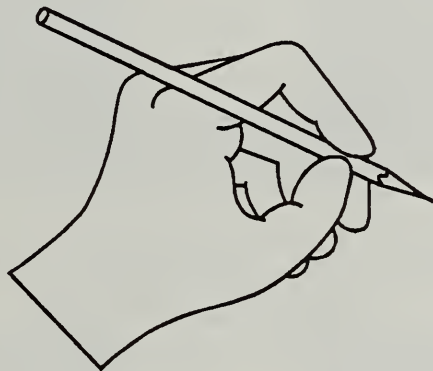
**Woods, Jerrye A.**, Pediatrics. Born September 14, 1963, Little Rock. Medical education, UAMS, 1991. Internship, UAMS.

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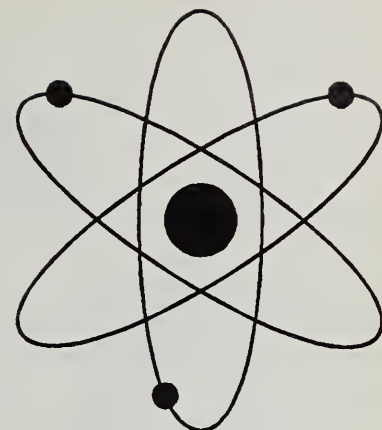
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# Radiological Case of the Month



David L. Harshfield, M.D.  
Steven R. Nokes, M.D.

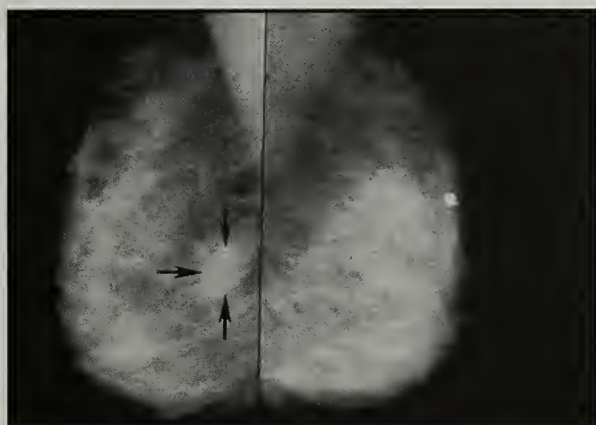


Figure 1. Medio-lateral views of breasts.



Figure 2. Cranio-caudad views of breast.

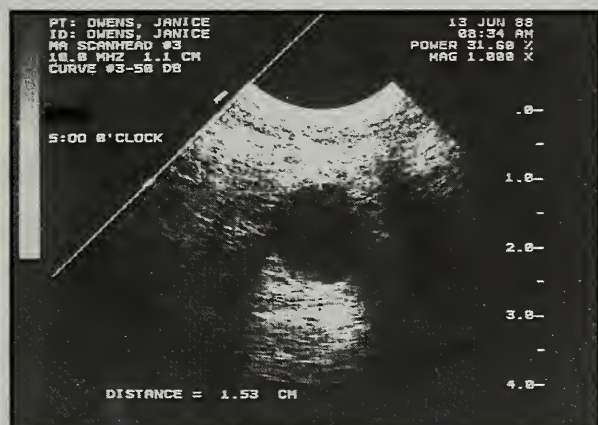


Figure 3. Ultrasound of cysts.

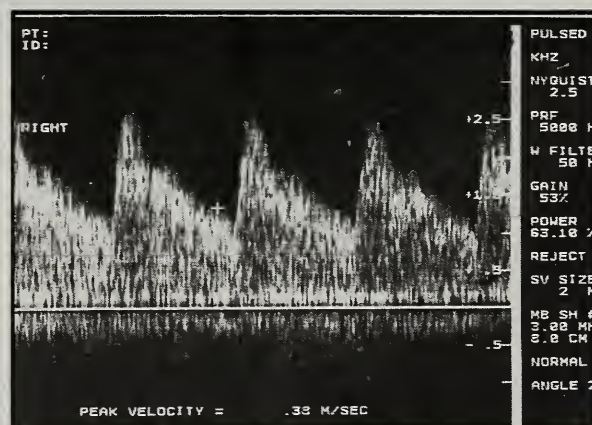


Figure 4. Doppler spectral analysis.

## History:

A 75 year-old white female with right breast mass of recent onset associated with minimal tenderness. The patient's mother had breast cancer at age 78.



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# Comedocarcinoma

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## Radiographic Findings:

The mediolateral views of the breasts (figure 1) reveal a considerable amount of remaining fibroglandular tissue (increased density) for a patient of this age group. In addition, there is a poorly circumscribed asymmetrical density seen deep in the right breast denoted by the black arrows. There is incidental notation of benign "popcorn type" calcification in the left breast of little significance in this patient.

The ultrasound exam (figures 3) reveals a well-circumscribed cystic lesion. Close scrutiny further reveals a thick echogenic (bright) rind which is demarcated from the surrounding breast tissue by a halo of low echogenicity (dark line). This already suspicious appearing "cyst" is further characterized by the Doppler flow obtained from its periphery. The spectral analysis (figure 4) reveals markedly elevated systolic and diastolic flow patterns with low resistive index of .5 indicating high blood flow. Subsequent biopsy of the lesion revealed the uncommon diagnosis of comedocarcinoma and a right mastectomy was performed.

## Discussion:

For some time, mammographic detection of breast cancer has been known to improve patient's outcome and reduce morbidity and mortality associated with this prevalent disease. This case points up the potential for misdiagnosis which could have occurred if the appearance of this lesion had been interpreted as a benign cyst. Recently there has been considerable interest in applying Doppler interrogation along with ultrasound imaging of breast masses to further classify these lesions. Utilizing Color Flow technology, we have found that benign (as well as malignant) lesions have flow which can be characterized. This information can help reduce the number of extensive and disfiguring biopsies of benign lesions. It is becoming apparent that benign breast lesions cycle with the ovaries and hence have a phasic, changeable flow pattern over the course of a month. Malignancy has not been documented to demonstrate this cyclical nature. That is, any solid lesion with typical imaging characteristics and cyclical blood flow patterns could be spared unnecessary biopsy, which in addition to physiological impaction on the patient results in scarring, making interpretation of subsequent mammograms more difficult. Along this same line, we have found that patients who are on oral Estrogen supplementation (who are either surgically or naturally menopausal) have a proliferation of the normal fibroglandular tissue in the breast. This has been reported to result in dense mammograms, and thus it follows that sonographically and by Duplex Doppler and breast tissue will demonstrate proliferative changes and increased flow pattern in these circumstances. We have documented many lesions that have developed in post-menopausal females on oral hormone supplementation which after cessation of Estrogen stimulation resulted in decreased blood flow consistent with this benign physiological phenomenon. Much is now understood about proliferation of breast tissue and its cyclical nature. This understanding coupled with our ability to detect flow patterns, as well as mammographic structure of breast lesions, is allowing us to avoid many unnecessary and disfiguring biopsy procedures in females with benign disease. Because although, one out of 10 women have breast cancer, nine out of 10 do not.

## References

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*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

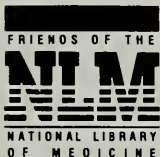
*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

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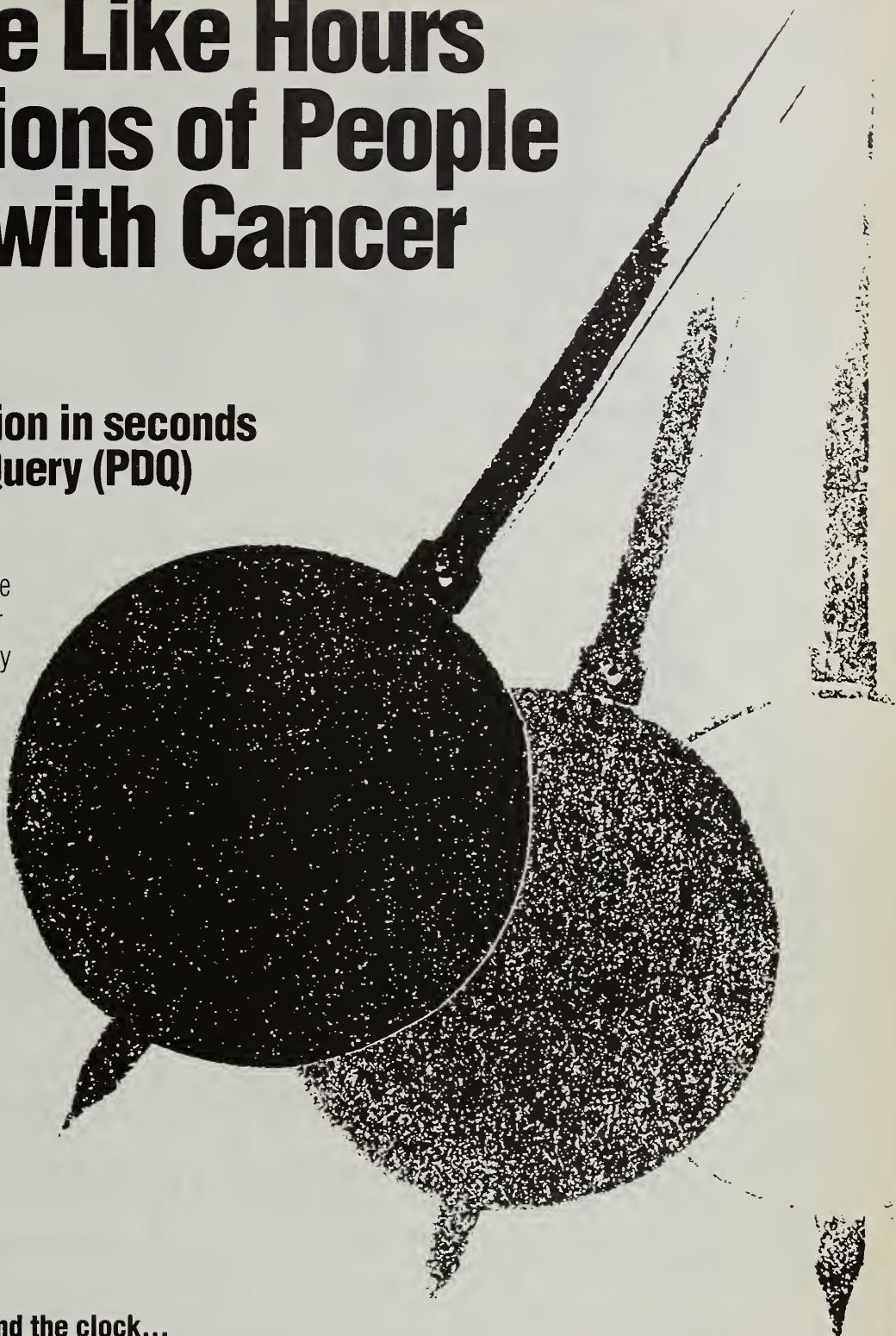
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# In Memoriam \_\_\_\_\_

## **Edwin F. Gray, M.D.**

Edwin F. Gray, M.D., of Little Rock, died Saturday, June 1, 1991. He was 80.

Dr. Gray was a retired radiologist with Radiology Associates and was in the Army Medical Corps from 1942-1946.

Dr. Gray was a member and past president of the Pulaski County Medical Society, a member of the Arkansas Medical Society, American Medical Association, Radiology Society of North America, American Roentgen Ray Society, a fellow of the American College of Radiology, a member of the Pulaski County Cancer Society and the Red Cross of Pulaski County.

Dr. Gray is survived by a daughter, Judy Gifford of Morrilton; four grandchildren; and a great-great-grandchild.

## **Ruth Finnegan Gray**

Ruth Finnegan Gray, of Little Rock, died Saturday, June 1, 1991. She was 79.

Mrs. Gray was a member of the Arkansas Medical Society Auxiliary.

Mrs. Gray is survived by a daughter, Judy Gifford of Morrilton; two sisters, Faye Symanyck and Dorothy Drew of Little Rock; four grandchildren; and a great-great-grandchild.

## **Alice Marie Hogue**

Alice Marie Hogue, of Benton, died Monday, May 27, 1991.

Mrs. Hogue was a member of the Arkansas Medical Society Auxiliary.

Mrs. Hogue is survived by her husband, Dr. Paul Hogue; two sons, Dr. Robert P. Hogue of Benton and Curtis E. Hogue of Fayetteville; a daughter, Cynthia M. Hogue of Benton; and five grandchildren.

## **Malcolm Peeler, M.D.**

Malcolm Peeler, M.D., of Jonesboro, died Tuesday, June 11, 1991. He was 75.

Dr. Peeler was a retired physician and surgeon and served as head of the emergency room at St. Bernard's Regional Medical Center. He was a past president of the Craighead-Poinsett County Medical Society and a member of the Arkansas Medical Society.

Dr. Peeler is survived by his wife, Roberta Stewart Peeler; a son, Andy Peeler of Jonesboro; a daughter, Karen Peeler of Waco, TX; a sister, Lolita Peeler Nash of Jonesboro; and two grandchildren.



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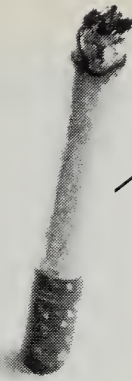
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*"Nah,  
I've smoked  
for  
30 years.  
It's too late."*




*"I've tried a  
million times,  
but I just  
can't."*



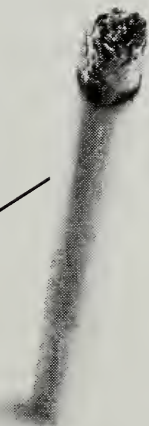
*"I'll  
quit  
next  
week."*




*"I'll quit  
next year."*



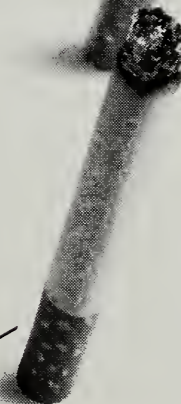
*"What difference does  
it make? I'm already  
52 years old."*



*"It's one of the  
few pleasures  
I have left."*



*"I've got  
other things  
to worry about."*



*"The damage  
is done."*

## **They know why they can't. Now tell them how they can.**

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So listen to their reasons for not quitting, then go ahead and give them the facts.

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# Medicine in the News

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## Health Care Access Foundation Update

As of March 1991, the Arkansas Health Care Access Foundation has provided free medical services to 2,837 medically indigent persons.

The program has 1,468 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## New Smoking Law Introduced

Hello, my name is Tina Shelton. I am president of the State Medical Board in Little Rock, Arkansas, and I am trying to get a law passed that forbids smoking in public places. The following is a proposal I have prepared to present to the state legislature.

### Is It The Truth?

The truth about cigarette smoking is that not only is it harmful to the smoker but also the person or persons around him; you see, side-stream smoking can be even more harmful than smoking a cigarette because there is more carbon monoxide given off in the smoke exhaled than the smoke inhaled. Second-hand smoke can be breathed by any innocent bystander. It is also true that over half a million die each year from lung cancer and other diseases caused by cigarette smoking.

### Is It Fair To All Concerned?

I believe as a non-smoker that my plan is fair to both sides. What a person does in his home is his business and whether or not he smokes in the privacy of his own house is his own business. On the other hand, what a person does in public concerns more than just his household, as many people become sick from breathing side-stream smoke. That is certainly unfair to the non-smoker.

### Will It Build Goodwill And Friends?

Yes, it should build goodwill and better friendship. Consider the following example: A smoker and non-smoker are standing next to each other, and the smoker lights up a cigarette and begins to exhale clouds of smoke. Meanwhile the non-smoker (becoming extremely disgusted) asks the smoker to put his cigarette out. The smoker becomes very offended, and it escalates from there. So if people couldn't smoke in public, there would be no conflict.

### Will It Be Beneficial?

Yes, for goodwill and health reasons, it would be beneficial. You see, it might just help smokers lose the urge to

smoke as much if they can't light up a cigarette whenever and wherever they want. It will also save non-smokers from the harmful effects of breathing the poisonous fumes from the smokers' cigarettes.

Of course I'm not really president of the State Medical Board, but the facts that I have presented in this essay support my viewpoint on the subject. As a citizen of Arkansas I believe that these changes would be for the betterment of life in our state. Even though the beginning of this is fiction, if I were on the State Medical Board, I would make these proposals to our state's lawmakers for the good of all citizens of Arkansas.

*-This is an essay written by Tina Shelton, an eighth grade student at Pulaski Heights Junior High School in Little Rock. The essay is Tina's entry for a contest sponsored by the Little Rock Rotary Club. The contest required each student to propose a particular law to the state legislature that they felt would be beneficial to the state of Arkansas. Tina was awarded 2nd place for her entry in the contest.*

## Fighting AIDS Through Education

Medical students at the University of Arkansas for Medical Sciences have created the most ambitious AIDS education program in the country among all those instituted by U.S. medical students, according to the American Medical Association's division of student services located in Chicago.

The program at UAMS, called Fighting AIDS Through Education (FATE), is a community service project of the sophomore medical class. During the past three years, student volunteers have spoken to more than 17,000 school-age students across Arkansas, a number more than twice the community contacts made by the other of the nation's 127 medical schools.

FATE's presentation in Arkansas schools provides much more than a break from the monotony of the school day. Nationwide efforts dispel myths and misunderstandings about AIDS remain the most effective weapon in the arsenal against AIDS and it is especially important that teenagers have access to the facts.

## HIV Insurance Available to Physicians

Physicians who face the risk of occupational exposure to HIV will now be able to obtain insurance protection for that risk through the American Medical Association's AMA Insurance Agency, Inc.

While traditional forms of medical, life and disability insurance may limit benefit payments to HIV-infected



physicians, the AMA plan will pay a lump sum benefit immediately after an insured physician tests positive for HIV infection. Benefits offer payments from \$150,000 to \$500,000 for practicing physicians. Residents can apply for \$150,000 or \$250,000 in coverage while medical students can obtain \$50,000 in coverage.

Premiums are based on the benefit level selected and are not tied to age, sex, location, or speciality. Annual premiums for practicing physicians choosing the \$500,000 benefit level will average \$900 to \$1,000. Coverage and premiums are guaranteed for five years following the effective date of coverage.

"Possible exposure to HIV infection has become a fact of life for today's practicing physician," AMA Executive Vice President James S. Todd, M.D., said. "Now physicians can face that fact with the confidence that financial obligations will be met."

The insurance will be available in a 10-state test market this summer with full national availability by the end of this year.

## Chronic Hepatitis Treatment Approved

**Intron A**, Schering-Plough Corporation's brand of alpha interferon, was approved today for the treatment of treatment of chronic hepatitis Non-A, Non-B/C, an insidiously progressive and sometimes fatal liver disease.

"The approval of **Intron A** for this indication is important because, until now, there has been no effective treatment for chronic hepatitis Non-A, Non-B/C — a disease that we think affects many more people than the number reported," said Gary L. Davis, M.D., associate professor of medicine at the University of Florida, Gainesville, and an investigator in a multicenter trial on **Intron A**.

Each year, an estimated 170,000 Americans become acutely infected with hepatitis Non-A, Non-B/C. Of those, 42% have a history of intravenous (IV) drug use and 6-10% have a history of blood transfusion. The remaining become infected through other modes of transmission, including hemodialysis, sexual contact with an infected partner, occupational exposure to infected blood or blood products, and unidentifiable sources.

At a dose of three million units, employed in three clinical trials, **Intron A** produced significant improvements in levels of ALT (serum alanine aminotransferase), an enzyme that, when elevated, generally indicates liver damage. Statistical analyses of the pooled data from the three studies showed that 54% of patients experienced significant improvements in ALT levels, compared with 11% of patients who responded to Intron A, 70% achieved a reduction in ALT levels to normal, 18% to near normal, and 12% achieved a partial response. Improvements in liver tissue was also seen compared to untreated patients.

Side effects reported in the clinical studies usually were mild to moderate and included such flu-like symp-

toms as muscle ache, headache and fever. While most patients experienced side effects, these effects were manageable and generally diminished during treatment. Patients with uncontrollable thyroid problems, psychiatric disorders, and those under age 18 should not be treated with **Intron A**.

## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of April and May are:

John H. Adametz	Little Rock
William E. Atkinson	Little Rock
Charles W. Ball	Little Rock
Robert L. Berry	Little Rock
Jack L. Blackshear	Little Rock
Roger E. Cagle	Paragould
James W. Campbell	Little Rock
Donald L. Cohagan	Bentonville
Rickie A. Conrady	Newport
Robert D. Dickins	Little Rock
James P. Florez	Little Rock
Edward P. Hammons	Forrest City
Guy Heder	Portland
Michael C. Hendren	Russellville
Dale E. Johnston	Little Rock
Gordon W. McCraw	Fort Smith
Kelly H. Meyer	Russellville
John M. Moore	Little Rock
Debra J. Morrison	Little Rock
Robert W. Ross	Van Buren
Joanna J. Seibert	Little Rock
Donald Toon	Crossett
James R. Weber	Jacksonville
Frank M. Westerfield	Little Rock
Robert H. White	Malvern
William D. White	Searcy
William W. Williams	Monticello
Thomas H. Wortham	Jacksonville



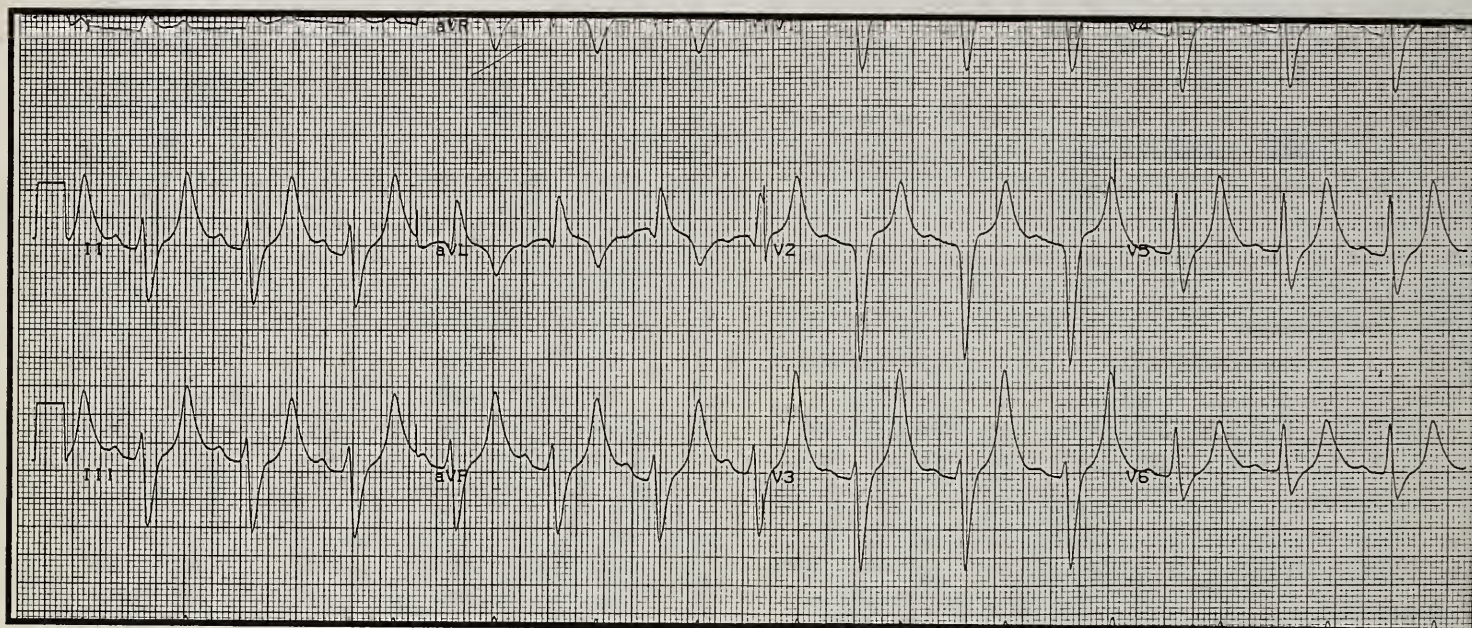


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## CLINICAL HISTORY:

This record was obtained from a 35 year-old male with end stage renal disease on chronic hemodialysis who last dialyzed five days prior to admission. He presented with complaints of malaise, fever, nausea, vomiting and diarrhea.



## DISCUSSION:

The rhythm is normal sinus at a rate of 80 beats per minute. The PR interval is 190 msec, the QRS duration is 180 msec and the QT interval is 540 msec. The T waves are tall, peaked and symmetrical. The finding of tall, symmetric, and "tented" T waves with QRS widening is virtually diagnostic of hyperkalemia. The patient's serum potassium at the time of this recording was 7.8 mEq/L. Such changes are typically seen with serum potassium levels between 5.5 and 7.8 mEq/L. Greater elevations in serum potassium are associated with further widening of the QRS, ST segment depression, loss of R wave amplitude (to the extent that T wave amplitude may exceed R wave amplitude) and loss of the P waves. At serum potassium levels  $\geq$  10 mEq/L, a so-called "sine-wave" pattern may appear, where the QRS blends with the T wave to produce a diphasic curve. Tall precordial T waves may also be observed early in the course of acute myocardial infarction, but these T waves are usually broad based and asymmetric, with the ascending limb of the T wave longer than the descending limb. Tall T waves may also be observed in true posterior infarction, in which case the T wave abnormality tends to be localized to the right precordial leads and to be associated with tall R waves.



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**Michael King, M.D.**  
**Steven Nokes, M.D.**  
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# Things To Come

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## July 31-August 4

**SAO's 4th Annual Meeting.** Crystal Palace Resort & Casino, Nassau, Bahamas. Sponsored by the Southern Association for Oncology. For more information, call (205) 942-0530.

## August 1-3

**Financial Management Conference.** Mariner's Inn, Hilton Head Island, SC. Sponsored by the Medical College of Georgia. For more information, call Donald Murphy or John Norcross at 1-800-221-6437.

## August 7-11

**SOA's 8th Annual Meeting.** The Broadmoor, Colorado Springs, CO. Sponsored by the Southern Orthopaedic Association. For more information, call (205) 945-1848.

## August 21

**1991 General Loss Prevention Seminar.** Airport Hilton Inn, Memphis, TN. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## August 22

**1991 General Loss Prevention Seminar.** Airport Hilton Inn, Memphis, TN. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## October 2-12

**Allergy Abroad.** Hong Kong & Guilin, China. Sponsored by the Division of Allergy and Immunology and the Office of Continuing Medical Education, Washington University School of Medicine in St. Louis, MO. For more information, call (800) 325-9862.

## October 13-17

**Joint Meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology.** Anaheim Convention Center, CA. Sponsored by the American Academy of Ophthalmology. For more information, contact Linda Whitfield, (415) 561-8500.

## November 7-8

**National Conference on Alcohol & Other Drug Abuse: Changing Lives Through Research & Treatment.** Meharry Medical College, Nashville, TN. Sponsored by the Meharry Medical College. For more information, call (800) 669-1269.

## November 16-19

**SMA's 85th Annual Scientific Assembly.** Georgia World Congress Center & Atlanta Hilton & Towers, Atlanta, GA. Sponsored by the Southern Medical Association. For more information, call (800) 423-4992.

## TAKE THE FIRST STEP TO RECOVERY

The Physicians' Health Committee exists for you, the physician who is struggling with drug and/or alcohol addiction. The Committee is composed primarily of physicians who have "been there" and want only to help their colleagues from making the same mistakes.

The Committee members are willing to set up interventions, recommend treatment, and help with after-care and re-entry.

The Committee is not involved in any legal, moral or punitive judgements.

## ON CALL FOR YOU

Don't throw away your profession because of drugs and/or alcohol. Contact our Physicians' Confidential Assistance Hotline at (501) 370-8221. Only specially trained personnel will return your call. Or contact the Arkansas Medical Society office (501) 224-8967 or 1-800-542-1058 and ask for the name of one of the Physicians' Health Committee members.

*All inquiries are confidential within the Committee and no names or locations are necessary when contacting the Society office.*

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# Keeping Up

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## **1991 General Loss Prevention Seminar**

July 20, 9:00 a.m. - 11:00 a.m., Hilton Hotel, Fayetteville. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## **Breast Cancer**

August 20, 7:00 p.m., Education Department, Baxter County Regional Hospital. Sponsored by Baxter County Regional Hospital and presented by Bruce White, M.D. Category I credit offered.

## **AAFP 44th Annual Scientific Assembly**

August 1-4, Excelsior Hotel/Statehouse Convention Center, Little Rock. Sponsored by Arkansas Academy of Family Physicians. Nineteen AAFP prescribed hours. For more information, call Carla Coleman at (501) 223-2272.

## **The Seasonal Child**

September 17 and December 3, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building. Sponsored by ACH. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon*, second Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference* (varying topics), third Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
*Medical Grand Rounds*, Fridays, 12:00 noon, VAMC

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar*, third Thursday, 12:00 noon, Sturgis Auditorium  
*Genetics Conference*, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
*Infectious Disease Conference*, second Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, first Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, fifth Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, first Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Dunkerton/AP&L room. Lunch provided  
*Chest Conference*, second & fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
*GYN Surgery Cancer Conference*, second Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
*Hematology-Oncology Conference*, second Thursday, 12:00 noon, Pathology classroom. Lunch provided  
*Cancer Center Team Conference*, third Thursday, 12:00 noon. Lunch provided  
*Sleep Disorders Case Conference*, every other Thursday, Video Production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, second Friday, 12:00 noon. Sandwich buffet served

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, third Thursday, 7:00 a.m., conference room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Pathology Conference*, first Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided



*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; second & fourth Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, sixth Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*CARTI North Tumor Board Cancer Conference*, second Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, fourth Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, second Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, third or fourth Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Research Conference*, three Wednesdays a month, 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Ob/Gyn Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, first Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, fourth Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, second, third, & fourth Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Tumor Conference*, Tuesdays, 4:00 p.m., VAMC-LR, Pathology conference room

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, first & fourth Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, third Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, second Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, first, second & fourth Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, second Tuesday, 12:15 p.m., AHEC-South Arkansas



*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, fourth Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, first, second & third Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

#### FAYETTEVILLE - AHEC NORTHWEST

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursday, 7:30 a.m., Washington Regional Medical Center

#### FORT SMITH - AHEC

*Renovascular Hypertension or Metabolic Acidosis/Alkalosis*, July 30, 12:00 noon, 7th floor dining room, Sparks Regional Med Center  
*Problems with Blood Volume in Newborns*, August 7, 12:00 noon, 7th floor dining room, Sparks Regional Medical Center  
*Good Medicine 1991: Politics & Art*, August 20, 12:30 p.m., Library, Sparks Regional Medical Center  
*PUD/DUD*, August 21, 12:00 noon, 7th floor dining room, Sparks Regional Medical Center  
*Practice Management*, August 30, 12:30 p.m. Library, Sparks Regional Medical Center  
*Neuroradiology Conference*, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center

#### JONESBORO-AHEC NORTHEAST

*AHEC Lecture Series*, first & third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, second Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, first Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, fourth & fifth Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, third Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro

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*Neuroradiology Conference*, third Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, second Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, third Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, third & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## PINE BLUFF-AHEC

*Behavioral Science Conference*, first & third Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, second & fourth Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, first & fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, third Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, second & fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, second Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, second & fourth Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, third Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, third Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
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## Advertisers Index

Advertising Agencies in italics

American Medical Association .....	113
American Physicians Insurance Exchange .....	inside front
<i>McNabb/DeSoto &amp; Company</i>	
Arkansas Express Claims .....	91
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Central Arkansas Rehabilitation Hospital ....	back cover
Collom & Carney Clinic Association .....	104
Eli Lilly & Company .....	88
<i>Garrison, Jasper, Rose &amp; Company</i>	
Tommy Farrell Associates .....	81
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	119
Freemyer Collection System .....	104
Medical Protective Company .....	101
<i>Ferguson Advertising, Inc.</i>	
Medical Protective Company .....	115
Mediquik Walk-In Clinics .....	85
MEDX .....	118
National Heart, Lung & Blood Institute .....	109
National Library of Medicine .....	107
Rather, Beyer & Harper .....	104
Reed & Carnrick .....	82
<i>Gross Townsend Frank Hoffman</i>	
State Volunteer Mutual Insurance Company .....	78
<i>The Maryland Group</i>	
Tanyard Springs .....	77
<i>A. Tim Irby Advertising, Inc.</i>	
U.S. Air Force .....	93
<i>Bozell, Inc.</i>	
University Cardiothoracic Surgery .....	108

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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 3

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## CONTENTS

### FEATURES

- |     |  |
|-----|--|
| 124 | The Case for the Single Case Report<br><i>Editorial</i><br>John Olson, M.D.  |
| 127 | CARE Report on Health Care Services  |
| 130 | Undergraduate Preparation for Occupational Health Nursing<br>Mona Ray Fields, Ed.D, R.N.<br>Paul Roundtree, M.D.<br>Mary Ann Coleman, B.S. |
| 135 | Fertility Trends in Arkansas, 1980-88: An Analysis by Age, Marital Status, and Color<br>Lawrence L. Santi, Ph.D.                           |
| 142 | Use of Hematopoietic Growth Factors in Patients with HIV Disease<br>Joseph M. Beck, M.D.   |
| 146 | James Issac Scarborough, M.D.<br><i>From Other Years</i><br>Edwina Walls, M.L.S.   |

### DEPARTMENTS

- |     |                                |
|-----|--------------------------------|
| 140 | AIDS in Arkansas Statistics    |
| 148 | New Members                    |
| 149 | Radiological Case of the Month |
| 152 | AMS Newsmakers                 |
| 155 | In Memoriam                    |
| 156 | ECG of the Month               |
| 158 | Things to Come                 |
| 160 | Keeping Up                     |

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# The Case for the Single Case Report

John Olson, M.D.

An old adage warning against a "country doctor with manure on his shoes and a case to report" has often been quoted and probably implies that one should not listen to such a person as you probably would not learn very much.

However, I do believe that there is a place in our medical literature for single case reports providing they are of extreme rarity and are or could be of clinical significance.

In a surgeon's life, rare cases do occasionally present themselves and are worthy of being submitted for publication, rather than collect dust on the shelves. Very often, as is the case I am reporting, on enteroliths in a Meckel's diverticulum, no mention is made of the entity in classical textbooks of surgery, such as Schwartz or Sabiston. Only by researching the literature will other cases be found, and frequently in only small numbers. One will find that "there is nothing new under the sun" and someone has been there first. Adding another case or two will add to the knowledge of such rarities.

A journal such as *The Journal of the Arkansas Medical Society* affords a good medium to publish such cases.

## Multiple Enterolith Formation in an Unusual Meckel's Diverticulum

Meckel's diverticulum was first described in 1832 by Johann Friedrich Meckel. Although rare, it is the most frequent malformation of the gastrointestinal tract and at the most probably occurs in 1-2% of patients.

Calculi in a Meckel's diverticulum is the most rare complication and had been reported in only 30 cases up to 1977 according to Hugo G. Bogren and Lars Billing of Sweden<sup>4</sup>. It has been found that they occur in older individuals as a rule<sup>3</sup>.

Bleeding<sup>1,3</sup> inflammation<sup>3</sup> and intestinal obstruction,<sup>5</sup> the usual complications of a Meckel's diverticulum have also been reported in conjunction with a Meckel's containing enteroliths.

Small bowel obstruction has been reported<sup>3</sup> by a large enterolith being extruded into the lumen of the small bowel causing a mechanical blockage.

## Case Report

On June 9, 1987, while performing a low anterior resection for carcinoma of the lower sigmoid colon in a 74-year old female (Hospital #28-54-77), it was discovered that the patient had a Meckel's diverticulum of unusual appearance. Instead of the usual configuration, it resembled a tiny hand and forearm with "chubby" fingers (see illustration). Each of these "fingers" contained what resembled a gallstone and they were quite hard and grayish-black in appearance (see illustration).



Meckel's diverticulum containing calculi.

(The illustration does not accurately depict the anomaly as it had been in formalin and was shrunken in appearance.)

Removal was accomplished using a stapling device and the patient made an uneventful recovery. Analysis of the "stones" was done and they were found to have oxalates as the major component, with phosphates also being present. Their size ranged from 1/2 cm to almost 1 cm in diameter. I was unable to find the literature an anatomical configuration such as this, as most of the cases were found to have multiple calculi occupying the main lumen of the diverticulum. It is felt that the enteroliths form due to stasis and are not gallstones as has previously been suggested.

## Summary and Conclusions

A case of unusual variant of a Meckel's diverticulum containing multiple enteroliths has been described. Although in this case, probably no clinical symptoms were present, it is obvious that hemorrhage, inflammation or obstruction could occur in the future. In this case, removal was definitely indicated.

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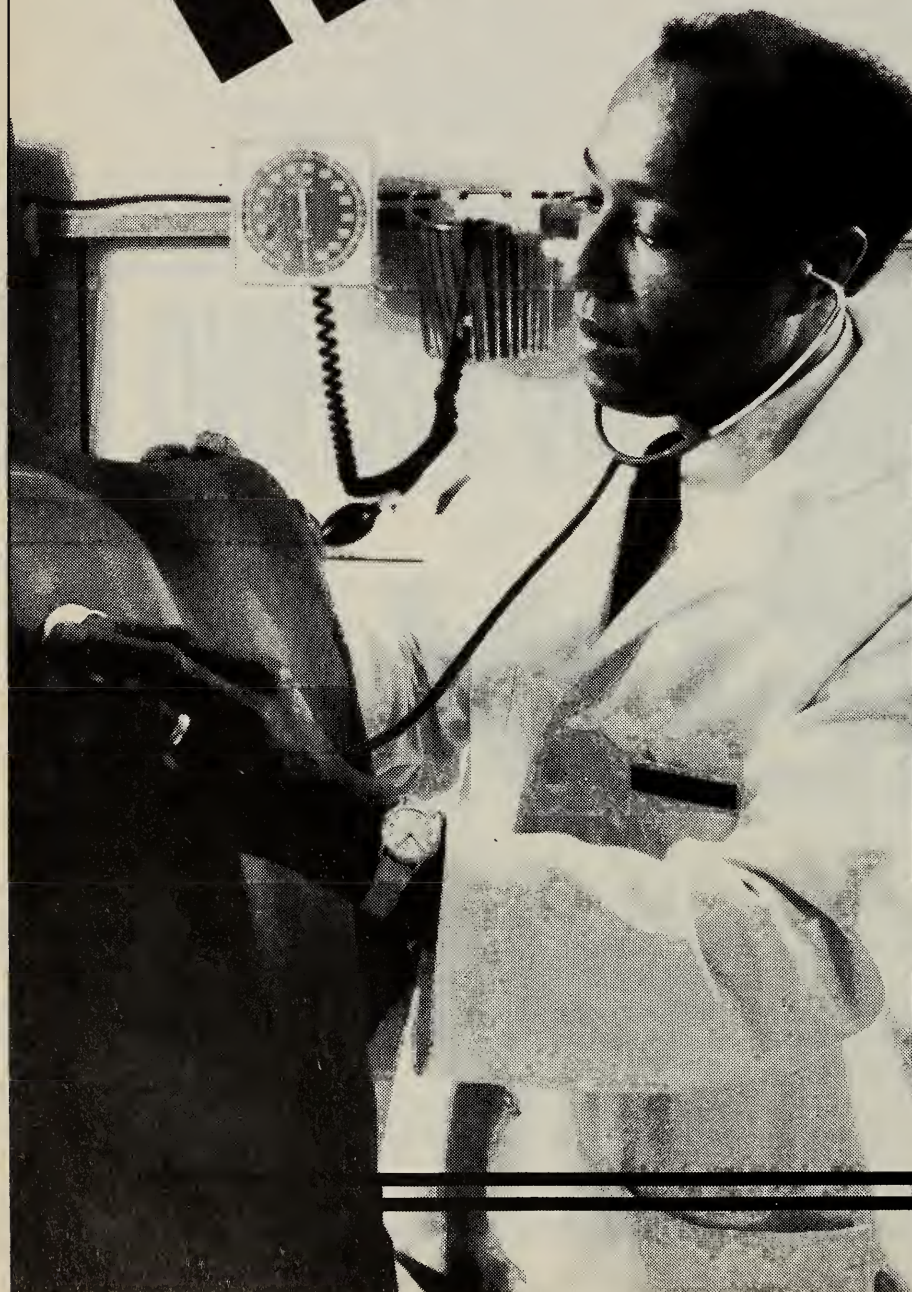
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# CARE Report on Health Care Services

In August 1989, a citizen task force was formed to examine the condition of the community following the overt racism exhibited when activist attempted to burn a flag on the steps of the Capitol. The members of the task force called CARE, the Community Advocates for Racial Equity, are: Martha Almon, an active volunteer in the Little Rock School District; Rev. J.E. Booker, pastor of St. Peter's Rock Baptist Church; Dr. Roosevelt Brown, a Little Rock dentist; Deborah Hilliard, editor of Arkansas Catholic; Bettye Fowler Kerns, Pulaski County School District library media specialist; Ron Lanoue, regional director of the National Conference of Christians and Jews; Janis Kearney Lunon, publisher of the Arkansas State Press; Larry Mabry, claims manager for Blue Cross/Blue Shield of Arkansas; and, Mildred Terry, a retired teacher. More than 150 individuals participated in nine committees which examined the status of the community in one of the following areas of concern:

Arts	Business
Education	Health Care Services
Housing	Justice
Religion	Youth Services
Media and Communications	

The following is a summary of their report on Health Care Services.

The Health Care Services Committee recognizes that any analysis of the effects of racial disharmony on health care/health institutions in Pulaski County would be inaccurate were it to view Pulaski County's problems in isolation. Specifically, the following broader concepts must not be ignored:

1. The disparity in the health status between blacks and whites is a well-documented national problem ("Report of the Secretary's Task Force on Black and Minority Health," *U.S. Department of Health and Human Services*, 2985: "Excess Mortality in Harlem," *New England Journal of Medicine*, Jan. 18, 1990).
2. Pulaski County as the largest Arkansas metropolitan center, has several features which make it unique in terms of health services, including both the state hospital and medical school. However, we believe misunderstanding between black and white populations in Pulaski County to be symptomatic of a state-wide problem. Additionally, some perceived problems in Pulaski County can only be solved through state action; e.g. continued recruitment of black students for the state's medical school.
3. We cannot divorce the economic disparity between the white and minority populations from the disparity in health status. Part of any long-term solutions to health problems will include solving the problem of an underpaid-unemployed underclass. Providing better pay and health insurance, less reluctance for financial reasons to seek necessary medical attention and more financial ability to provide nutrition, housing and health care for minority family members, young and old, must be made a priority by business and government.
4. Health care providers, whether the large teaching institution or the small physician's office, have both the promise and the problems of society at large. In putting on a uniform, a health care worker does not automatically become a paragon of racial understanding. However, health care workers, whether they be aids, technicians, physicians, nurses or administrators, are in such a position of intimacy with patients that unbiased attitudes are essential for good health care. The routine policy ought to be to foster and nurture such open-mindedness through formal education programs, rather than assume that old prejudices dissolve on undertaking a career in health care.

## Concern:

1. There continues to be a shortage of black physicians and upper-level health care administrators. Arkansas has



made strides in its recruiting of black undergraduates for medical school, but any solution to the health care problems of black Arkansans must recognize the role that black physicians play in providing health care to all our citizens, both black and white.

**Recommendation:**

- A. The University of Arkansas Medical School be commended for and encouraged to continue its efforts to recruit black physicians and other health care workers.
- B. That health care providers actively ensure that the staffing of their facility reflects the population they are serving at all levels of decision-making responsibility.

**Concern:**

- 2. While institutionalized racism in health care facilities has been greatly reduced, it has been difficult for the committee to determine the extent to which black patients are subjected to occasions of flagrant racist attitudes. One cannot over-emphasize the importance that a provider-patient relationship be a professional one, free of bias.

**Recommendation:**

- A. That one of our educational institutions, e.g. University of Arkansas Medical School, consider a formal survey to determine to what extent black citizens perceive they encounter racism in seeking medical care.
- B. That all facilities create a culturally friendly environment for both black and white patients. For example: waiting room magazines, pictures on walls, children's dolls and medical literature ought to immediately reassure all patients that they are welcome.
- C. That large health care facilities have well-established, clearly set policies regarding the importance of prejudice-free medical care.
- D. That small facilities, such as private physicians' offices, not consider themselves immune because of their size to the need for formal prejudice reduction training or clear policies regarding health care free of racial prejudice.
- E. That large health care providers and teaching institutions implement one of the formal programs for prejudice reduction. The committee recognizes that some hospitals/facilities have ombudsmen programs and oversight efforts to monitor episodes of flagrant racism. It is hoped that adoption of an ongoing prejudice reduction program through one of the proven educational models would improve racial harmony in our community as a whole, as well as contribute to better and harmonious patient care.
- F. The medical profession, purely through educational effort, has brought about monumental behavioral changes: the increased use of breast feeding over bottle feeding; the decrease in the use of cigarettes; the increase in public awareness of low versus high cholesterol diets; the advantages of exercise over a sedentary life style.

Such attitudinal shifts occur over years, not with a one-time conference. For these reasons, the committee recommends a long-term commitment to a prejudice reduction program.

**Concern:**

- 3. Racially biased attitudes are bad for all patients, both black and white. The committee heard information indicating that some white patients forego medical care rather than obtain it from black health care providers. Such attitudes must be viewed as part of our health care problems in Arkansas. For example, a young pregnant white teenager places herself and her developing baby in jeopardy if she misses out on prenatal care merely to avoid treatment from a black physician.

**Recommendation:**

- A. That public officials contribute to education regarding the dangers of the legacy of racism on ALL our citizens, black and white.
- B. That education be done in health facilities that regard the importance of professional credentials, not ethnic or racial background, in performance of medical duties.

**Concern:**

- 4. Medicaid is the current program provided by the state to provide medical care to the poorest of the poor. Unfortunately, a significant number of physicians will not accept Medicaid. Two sequelae result: poor patients have a smaller selection of physicians from which to choose; poor patients who often have unreliable transportation are required to travel greater distances in order to get to a physician who accepts Medicaid.

**Recommendation:**

- A. That physicians be educated regarding the effects of medical clinics refusing to see Medicaid patients.
- B. That information be analyzed regarding to what extent and why some physicians are reluctant to see Medicaid patients. Such information could be then utilized to help Medicaid become more acceptable to physicians. This information is currently being gathered by the State Health Department.

**Conclusion**

The above recommendations are deliberately very limited in scope. They will not solve all health care problems in Arkansas or Pulaski County. But they can serve as a point of discussion for central Arkansas health care facilities, large and small, to evaluate their policies with regard to race relations: is our waiting room "culturally friendly?" Would be benefit from formal policies on race relations? Should we institute a program of prejudice reduction? Each decision made to actively address these kinds of issues not only encourages a harmonious community, but also contributes to better patient care.

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# Undergraduate Preparation for Occupational Health Nursing

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*Seven baccalaureate nursing programs in Arkansas were surveyed to ascertain what content pertinent to occupational health nursing was included in the curriculum. Programs were examined for clinical experiences in occupational health settings. All programs failed to include some of the needed content. None of the programs covered the Occupational Health and Safety Act and its importance in occupational health nursing. Only four of the seven programs offered clinical experiences ranging from a one day observation to a six week preceptorship in an occupational health setting.*

## Introduction

While nurses have worked as occupational health nurses since 1898 (Stanhope & Lancaster, 1987), nurse educators have given little systematic attention to the inclusion of specific content relative to occupational nursing practice nor clinical experience in industrial settings to prepare graduates to function in the beginning role of an occupational health nurse.<sup>1</sup> Based on the historical development of nursing education, the basic preparation should occur within baccalaureate programs of nursing.

Occupational health nursing is generally recognized as one subspecialty within the broader field of community health nursing. In 1964, the American Nurses Association

defined a community health nurse as a graduate from a National League for Nursing (NLN) accredited baccalaureate nursing program.<sup>2</sup> This standard followed an earlier move by the NLN (1959) which specified that community health nursing content must be taught in order for a baccalaureate nursing program to be accredited.<sup>3</sup> However, this standard does not speak to the specific content to be covered nor does it specify the type of clinical experience to be provided. The latest accreditation criteria (NLN, 1983) includes the three levels of prevention, the development of critical thinking, decision making, independent judgement, the research process, leadership and management, legal, historical, political, social, economic and ethical aspects of nursing.<sup>4</sup> This broad specification of content/processes allows the faculty wide latitude in how the curriculum is arranged and what specific content and clinical experiences are provided. However, today's nurse generalist is expected to be a safe practitioner in a hospital or nursing home institutional setting, home, school, community, and industrial non-institutional setting. For further detail see *Essentials of College and University Education for Professional Nursing*, American Association of College Nursing, 1986.<sup>5</sup>

Most occupational health programs now emphasize meeting the regulatory requirements of the federal and state governments, trauma care, occupational disease diagnosis, and health conservation. Keller and May (1970) stated that occupational health nurses must be competent in four general areas to function in an occupational health setting.<sup>6</sup> These are:

1. Assessment of the health needs of employees and appropriate interventions to promote and maintain their health.
2. Assessment of the work environment (either by self or in collaboration with the safety officer or environmental engineers).
3. Provide early diagnosis for illness and prompt, safe treatment for injury on the job.

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4. Provide programs for restoring and maintaining the employee's level of function when disability from disease or injury occur.

In a recent continuing education program, (Gliniecki 1989), reported that a survey of occupation health nurses in California indicated these nurses enacted the following roles:

1. Administrative functions such as defining scope and function of the nursing service, documenting client care, development/upkeep of a procedure manual, budgeting, insurance forms and reports, and reports to management and various governmental agencies.
2. Emergency care
3. Assessment and intervention for work related illness and injury
4. Health promotion and treatment of non-work related illness and injury
5. Counseling programs for alcoholism, drugs, absenteeism and other crisis and/or referral to community agencies
6. Health and safety education
7. Collaboration and consultation regarding workplace safety and planning
8. Worksite assessment for safety

The survey revealed that 40-70% of the nurses had the following health programs in place:

1. Health promotion and maintenance
2. Drug/alcohol/smoking programs
3. Screening heart disease/stress management
4. Diet/nutrition programs
5. Cancer screening programs
6. Cancer health education
7. Individual and group physical fitness

Gliniecki also stated that 49% of the nurse's time was spent in counseling, assessing of health problems, and screening and referring employees. Sixteen percent was spent in supervision or administration. Developing and conducting employee health education programs consumed 12% of the nurse's time while 8% was spent in environmental assessment and monitoring.<sup>7</sup>

The only current research found concerning occupation health nursing content in baccalaureate nursing programs was a study by Olsen and Kochenar (1989) published in the AAOHN Journal.<sup>8</sup> The authors surveyed all of the NLN accredited baccalaureate nursing programs (73) in the Midwest. Fifty-two of the programs responded. Each was requested to indicate the level of integration of 27 specific content areas/skills into their programs. The areas with lowest integration were retirement planning, toxicology, and ergonomics. The highest integration was for health education, health promotion and the Occupation Health and Safety Act.<sup>8</sup>

## Instrumentation

Through a content analysis of the current literature on occupational health nursing, the following content and skills were concluded to be necessary for beginning practice of nursing in an occupational health setting. The first area was emergency injury care. The second area was assessment for present state of employee health. This included such content and skills as interviewing techniques, employee physicals, differential diagnostic skills, use of treatment protocols, alcohol and drug screening, administering and interpreting health risk appraisals and employee counseling (group). The third general area dealt with health promotion strategies which included group need appraisal, program development using the need appraisal, development of exercise and physical fitness programs, and development of smoking cessation programs. The fourth area related to environmental hazard appraisal. The fifth area covered specific management knowledge and skills needed in an occupation setting which included Workman's Compensation rules and regulations, liaison with insurance carriers, collaboration with other management personnel, and collaboration with health care team members were included. The final area questioned whether or not students had clinical experiences in an occupational health setting and, if so, how much time was spent in the setting.

The tool was a very simple instrument asking for "yes" or "no" responses except for an item on the amount of time spent in an occupational setting. The questionnaire proved to be a major limitation of the study. In an effort to increase participation, the brevity of the instrument sacrificed specificity. No attempt was made to ascertain reliability. Content validity was high when compared with the Olsen and Kochenar and Gliniecki studies.<sup>7,8</sup>

## Methodology

The study used a survey approach. The questionnaire along with a self-addressed, stamped envelope was sent to the community health nursing faculty at each of the seven baccalaureate programs in the state. A cover letter was included asking the faculty to participate. The usual procedures guaranteeing privacy to the individual respondents were followed. All of the programs responded. The data that follows represent the actual number of responses to each item on the questionnaire. The researcher chose not to use Chi square or a similar data analysis method because of the small number of programs in the study.

## Data Analysis

The first area on the questionnaire was a single item on emergency care of injuries. The stem read, "Do you teach?" Four of the seven programs indicated emergency care was taught. When the investigator approached the medical-surgical faculty in her own program to ascertain if this was taught, the faculty answered "yes." However, probing elicited the information that control of hemorrhage and CPR



(cardiopulmonary resuscitation) comprised the total content. The investigator chose not to answer "yes" for her program because in her judgment these skills do not reflect the depth of content and skill in emergency care necessary to function safely in an occupational health setting. Based on the "yes" "no" response permitted on the questionnaire, it could not be determined how this item was interpreted by the other responding faculty members nor the depth of the content taught.

Area #2 of the questionnaire dealt with assessment of the present state of health of employees and treatment of physical diseases. The responses are presented in Figure 1.

Figure 1 Assessment of Health Status		
Content/Skill	Yes	No
Health Risk Appraisal	7	0
Interviewing Techniques	7	0
Alcohol and Drug Screening	5	2
Employee Physicals	3	4
Differential Diagnostic Skills	5	2
Use of Treatment Protocols	5	2

Note that only three programs prepare students to perform employee physicals. Yet five programs report teaching students to make differential diagnoses and to use treatment protocols. One is forced to question the interpretation of these items since differential diagnoses are made on the basis of physical examination data. The graduates of two of the seven programs in the state are certifiable by the Board of Nurse Examiners as nurse practitioners; therefore, these three skills are highly stressed in those programs. All seven programs teach interviewing skills and use of health risk appraisals.

The next general area surveyed was participation in group health promotion strategies (Figure 2).

Figure 2 Health Promotion Strategies		
Content/Skill	Yes	No
Group Need Appraisal	6	1
Program Development/Needs Based	4	3
Employee Counseling Groups	3	4
Development of Exercise/Fitness Programs	2	5
Development of Smoking Cessation Programs	1	6

Based on these results one might conclude that students are more skilled in needs appraisal than they are in what to do once a need is identified. Six programs teach strategies to be used to identify needs of a group. Yet only four include content on health program development as a generic skill. Given the magnitude of cost to the employer (\$336-\$601 per year, Kristein, 1983) for an employee to smoke and the hazards to the individual (heart disease, cancer, COPD), it is surprising how few programs are including smoking cessation strategies in the basic program.<sup>9</sup> Other health promotion programs get a little more coverage. This is definitely an area that needs strengthening.

The fourth area was environmental hazard appraisal. Only one item was included on the questionnaire. Four programs reported that they include content related to this area. It is interesting to note that in the Olsen and Kochenar study (1989), ergonomics and toxicology were two of the three lowest areas of integration in Midwestern programs.<sup>8</sup> There appears to be a need to know more about what content is actually taught in the programs responding to this questionnaire.

Management content was the fifth area on the questionnaire. The results are presented in Figure 3.

Figure 3 Management		
Content/Skill	Yes	No
Workmen's Compensation, Rules and Regulations	0	7
Liaison with Insurance Carriers	0	7
Collaboration with Health Care Team	7	0
Collaboration with Management	4	3

It is obvious that there are major gaps in the knowledge of the graduates of these programs regarding the laws pertaining to Workmen's Compensation. This means that employees must be willing to provide this information as part of the orientation, or nurses must identify the lack and learn it on their own. It is also noteworthy that no content about liaison with insurance carriers is included. In this era of cost containment, clients in other settings as well as in occupational health sometimes need assistance in negotiations with third party payers. It appears reasonable to suggest that both these areas need to be added to the curriculum.

The final two items concerned clinical experience in an occupational health setting. Four of the seven programs reported clinical experience in an occupational health setting. Two of the programs indicated this was a one day observation experience. Another stated all students spent one day in an occupational health setting and could elect to return for a two week concentrated experience. The fourth



program allows students to return for a six week (40 hours per week period if they choose this area for their practitioner setting.) Other students in that program have a one day observational experience.

The seven nursing programs reported wide variation in the content, processes and skills presented. All programs provided health risk appraisal, interviewing skills and collaboration with health care team members which are not specific to occupational health nursing. Only health risk appraisal might be particular to community health nursing. As indicated previously, the questionnaire was very general and did not specify the depth of content nor breadth and degree of skill expected relative to the items listed. Based on the experience with the author's own program, the degree of competence is probably over, rather than under, estimated. If industry is to be persuaded of the importance of hiring baccalaureate graduates to work in community health settings, such as occupational health programs, then these employers must be assured that these nurses are prepared to practice differently than associate degree or diploma graduates. Given the data in this study, one would question these assurances. Therefore, it appears imperative that content and skills necessary to practice in occupational health settings be added to these programs. Only then would new baccalaureate degree graduates be adequately prepared as beginning practitioners in an occupational health nurse role.

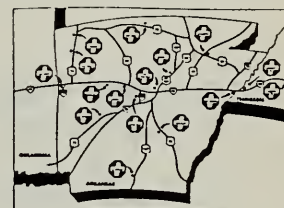
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# Fertility Trends In Arkansas, 1980-1988: An Analysis by Age, Marital Status, & Color

Lawrence L. Santi, Ph.D.\*

A number of vexing public policy questions in the state of Arkansas are either rooted in or exacerbated by the state's distinctive patterns of childbearing. Although these questions appear in a number of different guises and contexts, "teen pregnancy" and "births to unmarried women" being among the most common, they are all manifestations of the general phenomenon of childbearing or "fertility." Rather than focussing only on the more "problematic" aspects of Arkansas fertility patterns, it might be worthwhile to step back and take a more comprehensive look at these patterns.

The present paper hopes to provide this more comprehensive overview with an analysis of fertility trends in the state of Arkansas from 1980 to 1988.<sup>1</sup> In the light of their obvious public policy relevance, particular attention will be paid to fertility trends and differences by age, marital status, and color.

## Trends In Births By Marital Status And Color

Table 1 presents a number of ways of looking at change in patterns of births by marital status and color of the mother in Arkansas between 1980 and 1988. Panel A contains the basic data compiled by the Arkansas Department of Health's Center for Health Statistics (number of live births), while Panels B and C show change in numbers of births, in absolute and percentage terms, respectively. Panel D shows the percentage distribution of births by marital status for both color groups at the two points in time.

Looking at Table 1, we see that the total number of births to Arkansas women decreased from 37,145 in 1980 to 35,017 in 1988, a 5.7% drop. However, this gross decrease in the number of births obscures significant differences between the trends for married and unmarried women. Over the eight year interval under consideration, births to married women decreased from 29,502 to 25,754 (a 12.7% drop) while births to unmarried women increased from 7,643 to 9,263 (a 21.2% jump).

Although the general directions of these trends were the same for both white and non-white women, the magnitudes of the changes differed significantly between the two color groups. Births to married women declined by a greater percentage among non-white women than among white women (-26.5% versus -10.4%, respectively), while births to unmarried women increased by a greater percentage among white women than among non-white women (61.4% versus 3.1%).

**Table 1**  
**Births by Color & Marital Status of Mother**  
**Arkansas, 1980 and 1988**

### A. Number of Live Births

Color	1980			1988		
	Married	Unmarried	Total	Married	Unmarried	Total
White	25287	2372	27659	22657	3828	26485
Non-white	4215	5271	9486	3097	5435	8532
Total	29502	7643	37145	25754	9263	35017

Source: Arkansas Department of Health, Center for Health Statistics.

### B. Absolute Change

Color	1980-1988			1980-1988		
	Married	Unmarried	Total	Married	Unmarried	Total
White	-2630	1456	-1174	-10.4	61.4	-4.2
Non-white	-1118	164	-954	-26.5	3.1	-10.1
Total	-3748	1620	-2128	-12.7	21.2	-5.7

### C. Percentage Change

### D. Percentage Distribution

Color	1980			1988		
	Married	Unmarried	Total	Married	Unmarried	Total
White	91.4	8.6	100.0	85.5	14.5	100.0
Non-white	44.4	55.6	100.0	36.3	63.7	100.0
Total	79.4	20.6	100.0	73.5	26.5	100.0

\* Dr. Santi is division chief with the Division of Demographic Research Center for Research and Public Policy at the University of Arkansas at Little Rock.



**Table 2**  
**Marital Status by Age & Color**  
**Arkansas & U.S., 1980 and 1988**

Age	Arkansas					U.S.				
	1980		1988			1980		1988		
	% Mar.	Total	% Mar.	Total		% Mar.	Total	% Mar.	Total	
<b>All Colors</b>										
10-14	0.0	9875	0.0	87462		0.0	8745	0.0	8059	
15-19	12.1	105662	7.0	92742		7.4	10110	4.1	8907	
20-24	52.7	98679	42.4	92601		42.0	10246	32.5	9586	
25-29	72.1	88060	66.3	97496		64.9	9357	57.4	10854	
30-34	78.5	83496	75.6	92575		72.7	8561	67.2	10795	
35-39	79.9	68307	77.8	85570		75.8	7085	70.9	9533	
40-44	80.8	58463	78.0	76150		76.7	5957	71.1	8073	
<b>Total</b>	<b>49.8</b>	<b>593542</b>	<b>49.0</b>	<b>624596</b>		<b>45.5</b>	<b>60061</b>	<b>44.8</b>	<b>65807</b>	
<b>White</b>										
10-14	0.0	70179	0.0	66630		0.0	7232	0.0	6476	
15-19	14.3	82415	8.7	72989		8.2	8473	4.7	7224	
20-24	58.5	78536	48.0	73781		45.0	8664	35.2	7880	
25-29	77.3	71781	71.6	78989		68.8	7970	60.7	9019	
30-34	83.0	71144	81.6	75800		76.2	7357	71.4	8970	
35-39	83.6	59477	82.5	71986		79.3	6127	74.5	8033	
40-44	83.9	50539	81.3	66838		80.3	5142	74.2	6929	
<b>Total</b>	<b>54.6</b>	<b>484071</b>	<b>54.0</b>	<b>507013</b>		<b>48.4</b>	<b>50965</b>	<b>47.9</b>	<b>54531</b>	
<b>Non-white</b>										
10-14	0.0	20696	0.0	20832		0.0	1513	0.0	1583	
15-19	4.2	23247	1.6	19753		3.7	1637	1.4	1683	
20-24	30.0	20143	23.7	18820		25.7	1582	20.1	1706	
25-29	49.0	16279	47.3	18507		42.6	1387	40.9	1835	
30-34	52.7	12352	48.0	16775		51.6	1204	46.7	1825	
35-39	54.4	8830	52.9	13584		53.0	958	51.2	1500	
40-44	61.1	8830	60.0	9312		53.9	815	52.6	1144	
<b>Total</b>	<b>28.4</b>	<b>110377</b>	<b>29.2</b>	<b>117583</b>		<b>28.9</b>	<b>9096</b>	<b>29.6</b>	<b>11276</b>	

Yet despite these patterns of differential change by marital status and color, the percentage of all births occurring to unmarried women was and continues to be much higher among non-white women than among white women. Non-marital births constituted 55.6% of all live births occurring to non-white women in 1980, and this percentage increased to 63.7% by 1988. For white women, the percentage of non-marital births increased from 8.6% in 1980 to 14.5% in 1988.

The picture that emerges from these data is as follows. In both 1980 and 1988, the percentage of live births occurring to unmarried women was much higher among non-white women than among white women. At the same time, however, it is equally true that the percentage increase in births to unmarried women from 1980 to 1988 was greater among white women than among non-white women. In the

remainder of this article, we will attempt to make some sense out of these apparently paradoxical findings.

## Numbers Of Births Versus Fertility Rates

Thus far our discussion of Arkansas' fertility trends has been couched in terms of numbers of births, and the percentage of these births occurring to women of different colors and marital status. However, numbers such as these can tell us very little about the underlying dynamics of fertility, because they do not take into account the numbers of women of particular types that are "at risk" of experiencing childbirth. And once we take into account the size of the "at risk" population, we are dealing with fertility rates.

To illustrate this difference between numbers and rates, we have only to consider that an increase in the total number of births to unmarried women may be due entirely to an increase in the number of unmarried women in the population at large rather than to an increasing "propensity" of women to conceive and bear children out of wedlock. And it is usually these behavioral propensities, which cannot be observed until the data are expressed as rates, that are of greater interest to policy analysts.<sup>2</sup>

This difference between absolute numbers and rates is of more than academic significance and can lead to radically different policy analyses and interpretations. To return to our example, if an increase in non-marital fertility is due solely to an increase in the number of unmarried women, then attempts to "ameliorate" this situation might well focus on the factors that have made marriage a less common status for women. (And in view of

such well documented recent trends as the rising age at first marriage, increasing proportions of never married women, and increasing rates of marital disruption, such a focus is probably not misplaced.) If, on the other hand, it is shown that women of a certain age, marital status, and color are bearing children at higher rates than before, then our policies might well focus on factors that affect childbearing more directly (sexual activity, contraceptive practice, etc.).

## Constructing Fertility Rates

As should be clear from the preceding discussion, any "rate" consists of two components, a numerator that indicates the number of "events" occurring over some specified interval and a denominator that represents the number of



persons "at risk" of experiencing the event. A fairly simple fertility rate (known as the "general fertility rate") expresses the number of births as a proportion of all women of child-bearing age, conventionally reckoned as the ages of 15 to 44.

More refined rates require that both the events and the population at risk be classified by certain population characteristics, in the present case, by age, marital status, and color of the mother.

Fortunately, the Center for Health Statistics of the Arkansas Department of Health routinely compiles the requisite birth statistics on a calendar-year basis. Thus it was possible to readily obtain a cross-classification of births (the "event" of interest) by age, marital status, and color of the mother.

And for 1980, the total number of women (the population "at risk") cross-classified by age, marital status, and color, was readily available from the 1980 Census of the Population.<sup>3</sup>

Thus it was left only to construct denominators to correspond to the 1988 birth data, i.e., a cross-classification of Arkansas women by age, marital status, and color. This cross-classification was produced by UALR's Division of Demographic Research using a variety of data sources produced by the U.S. Bureau of the Census.

The first of these Census Bureau data products was a set of estimates of the population of Arkansas by age, sex, and color for the year 1988. (See U.S. Bureau of the Census, 1990, for details about these estimates.) This gave us a distribution of Arkansas women by age and color; we still needed to add a marital status dimension to the age by color distribution.

Unfortunately, no organization routinely produces estimated marital status distributions for states, so we had to create one for Arkansas using the best available (albeit limited) resources.

We began with the marital status by age and color distribution of Arkansas women as revealed by the 1980 Census (U.S. Bureau of the Census, 1983a and 1983b). Then we examined national-level trends in the marital status by age and color distributions using data from the Current Population Surveys of 1980 and 1988 (U.S. Bureau of the Census, 1981 and 1989). We applied these national-level age- and color-specific changes in marital status to the data for Arkansas to arrive at our 1988 distribution of Arkansas women by age, marital status, and color.

These data, and the U.S. data on which the patterns of change were based, are displayed in Table 2. These data provide the denominators upon which 1988 fertility rates were based. It might be worthwhile to examine the data in Table 2 in some detail, since it will prepare us for the analysis of fertility rates to be discussed in the following section.

We begin by noting that white women in Arkansas were considerably more likely to be married than were white women in the U.S. as a whole (54.6% married versus 48.8% as of the 1980 Census). The percentage married among non-white Arkansas women, however, was nearly identical to the

**Table 3**  
**Births Rates by Age, Marital Status & Color**  
**Arkansas, 1980 and 1988**

Age	1980		1988	
	Married	Unmarried	Married	Unmarried
<b>All Colors</b>				
10-14	*	0.2	*	0.2
15-19	34.9	3.7	43.0	4.1
20-24	21.9	5.8	22.3	6.3
25-29	13.9	3.7	12.7	4.3
30-34	5.6	1.8	6.1	2.6
35-39	1.7	0.9	1.8	1.1
40-44	0.4	0.3	0.3	0.3
Total	10.0	2.6	8.4	2.9
<b>White</b>				
10-14	*	0.1	*	0.1
15-19	34.3	1.6	42.0	2.2
20-24	21.3	2.4	22.1	3.5
25-29	13.5	1.6	12.9	2.7
30-34	5.2	0.8	5.9	1.9
35-39	1.5	0.5	1.7	0.7
40-44	0.3	0.1	0.3	0.2
Total	9.6	1.1	8.3	1.6
<b>Nonwhite</b>				
10-14	*	0.6	*	0.7
15-19	41.6	10.1	63.7	10.5
20-24	26.7	13.4	24.1	13.9
25-29	16.2	7.8	11.0	8.0
30-34	9.6	3.9	7.3	3.8
35-39	4.5	2.1	3.1	1.8
40-44	1.3	0.8	0.9	0.6
Total	13.5	6.7	9.0	6.5

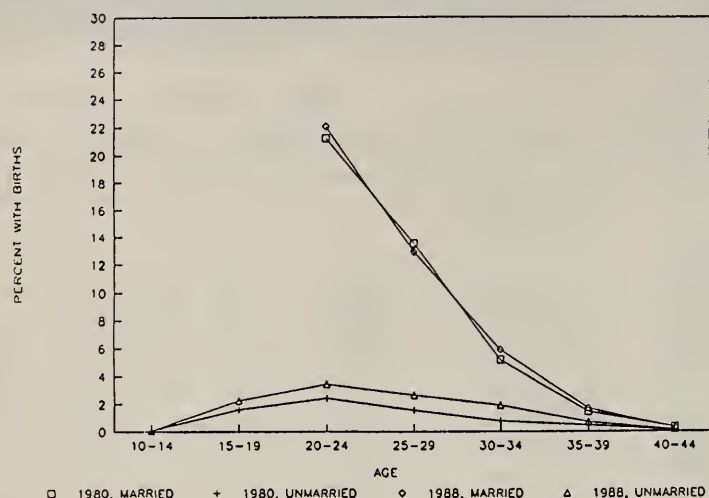
national percentage (28.4% compared to 28.9%).

In both Arkansas and the U.S. as a whole, white women were considerably more likely to be married than were their non-white counterparts. This was true not only in the aggregate but at every age (e.g., compare the 58.5% of white Arkansas 20-24 year olds who were married as of 1980 to the 30.0% figure that obtained for non-white Arkansas 20-24 year olds). This difference between aggregate and "age-specific" marriage proportions is essential to grasp in attempting to understand change in marital status distributions between 1980 and 1988.

Focussing on the U.S. data, we see that the aggregate percentage of American women who were married fell only slightly from 1980 to 1988 (from 45.5% to 44.8%). Indeed, the percentage married appears to have actually increased slightly among non-white women, from 28.9% to 29.6%.



**Figure 1**  
**Birth Rates of White Women by Age, Marital Status, and Year**



Yet, despite these aggregate-level outcomes, it is also true that the likelihood that a woman of a particular age and color was married decreased from 1980 to 1988 among all age-color segments of the population (e.g., the percentage married of white 20-24 year old women dropped by almost 10 percentage points while the percentage married of non-white 20-24 year olds dropped by approximately six points).

To understand this seeming paradox (that the aggregate percentage of women married changed only slightly even though age-specific percentages dropped considerably) we need to examine changes in the age structure that were occurring simultaneously with the drop in age-specific marriage percentages. For both the U.S. and Arkansas, the 1980's saw decreases in the number of women at the younger, low-marriage ages and increases in the number of women at older, higher-marriage ages, due to the aging of the large baby-boom birth cohorts. So that even as age-specific marriage probabilities were falling, the aging of the female population into higher-marriage age categories kept the aggregate percentage married relatively stable.

These patterns of change in the age and marital status distributions provide a "textbook" illustration of the role of changing population composition in demographic and other forms of social change.

### Trends In Fertility Rates By Age, Marital Status, And Color

Birth rates of Arkansas women by age, marital status, and color for the years 1980 and 1988 are presented in Table 3 and graphed in Figures 1 and 2. These rates express the number of births to women of a certain age, marital status, and color as

a percentage of the total number of women of that age, marital status, and color. Thus, the 34.9% figure for married 15-19 year old women of all colors in 1980 indicates that just over one-third of these women experienced a live birth during calendar year 1980; this number is not affected by the actual number of married 15-19 year old women but represents the "propensity" of women with these characteristics to bear children.

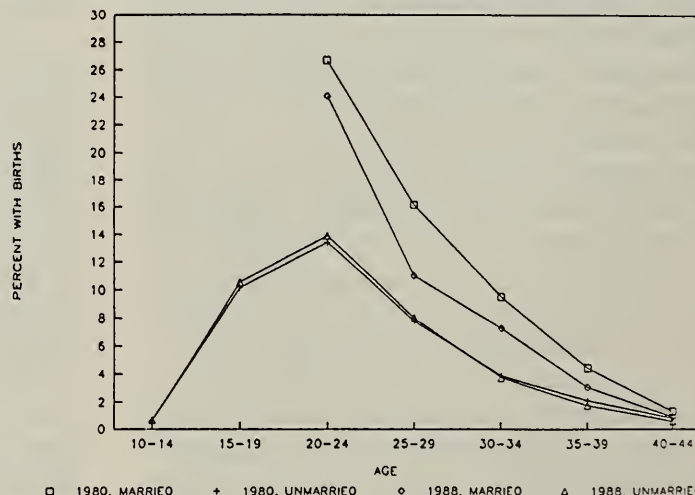
That this rate appears to have increased from 34.9% in 1980 to 43.0% in 1988 suggests an increase in the propensity of these young married women to bear children, despite the fact that the absolute number of 15-19 year old married women was estimated to have decreased over the same time period.<sup>4</sup>

Looking at the "Total" rows of Table 3, we see that aggregate marital fertility rates decreased for both white and non-white women over this eight year period, from 9.6% to 8.3% for whites and from 13.5% to 9.0% for non-whites. Aggregate non-marital fertility rates remained relatively stable over the eight year period, increasing slightly for white women (from 1.1% to 1.6%) and decreasing slightly for non-white women (from 6.7% to 6.5%).

But the real interest lies in the age and marital status specific fertility rates, whose patterns can perhaps be most readily observed in Figure 1 (for white women) and Figure 2 (for non-white women). Each of these graphs contains four lines, representing age-specific fertility patterns by marital status (married versus unmarried) and year (1980 and 1988).

Among married women, fertility rates are highest among 20-24 year olds and show steep declines with age. In terms of their basic shapes and magnitudes, the fertility curves of

**Figure 2**  
**Birth Rates of Nonwhite Women by Age, Marital Status, and Year**



white and non-white married women were not all that different in 1980 and appear to have become even more similar by 1988 by virtue of decreasing marital fertility among non-white women.

Turning our attention to unmarried women, we see that the fertility rates of non-white women are much higher than those of white women at virtually every age. The largest difference appears in the 20-24 year old age category, where 13.9% of unmarried non-white women and 3.5% of unmarried white women bore children in calendar year 1988.

However, as far as patterns of change are concerned, the age-specific fertility rates of unmarried non-white showed very little change from 1980 to 1988 while the rates of unmarried white women appear to have increased at every age from 15 to 34.

The major conclusions to emerge from this study may be succinctly stated. First, fertility rates among unmarried, non-white women were much higher than those of unmarried white women in 1980, and continue to be so in 1988. Nonetheless, in terms of change between 1980 and 1988, it was the fertility rates of unmarried white women that showed the greatest increase. Indeed, age-specific fertility rates among married white women and unmarried non-white women showed no change between 1980 and 1988, while age-specific fertility rates among married non-white women actually decreased over this eight year interval.

Thus, childbearing among unmarried non-white women has been and continues to be a significant phenomenon in Arkansas, as it is throughout the U.S. However, this analysis also shows that the problem has not worsened over the 1980's. The increase in the number of births to unmarried non-white women observed between 1980 and 1988 was due more to the aging of non-white unmarried women than to any increase in behavioral propensities to bear children. For unmarried white women, on the other hand, the increase in the number of births appears to be a function of both the aging of the population and increasing behavioral propensities to bear children. Considered together with fertility trends among married women, this analysis indicates increasing similarity in the fertility patterns of white and non-white women in the state of Arkansas.

## Notes

1. There is nothing particularly sacred about the particular interval, 1980 to 1988. However, 1980 is a convenient starting point because of the availability of data from the 1980 Census of the Population, and 1988 fertility data were the most current available at the time this research was initiated. We anxiously await data from the 1990 Census to conduct a more detailed and definitive analysis, but these data will probably not be available for a year or more.
2. It might be worthwhile at this point to note that one commonly used measure of teen fertility, the percentage

of all births born to mothers under the age of 20, is not immune to the same sorts of interpretive problems that plague raw birth statistics. An increase (or decrease) in the percentage of births to teenaged mothers may be due to an increase (or decrease) in actual childbearing activity among teenagers or to an increase (or decrease) in the numbers of teenaged women, or (more likely) to some combination of the two factors.

3. One problem with Census data is that the Census Bureau only reports marital status for persons 15 years of age and older. The implicit assumption is that the preponderance of persons under 15 years of age will be unmarried.

For this reason, we have adopted the convention that all young women under the age of 15 (and their births) are reckoned as unmarried women. This expedient should not greatly distort any of the subsequent analyses or interpretations. The proportion of young women under the age of 15 who are married is probably very small, and ADH statistics show that births to young women under the age of 15 constitute only 2% of all births to Arkansas women.

4. Exactly how much importance we want to attach to these illustrative observations about 15-19 year old married women is another question since they constituted only 12.1% of all 15-19 year old Arkansas women in 1980 and an even smaller 7.0% in 1988, and rates calculated on such small population bases can be quite volatile. Indeed, given the possible instability of this particular data point, it has been omitted from the accompanying graphs in Figures 1 and 2.

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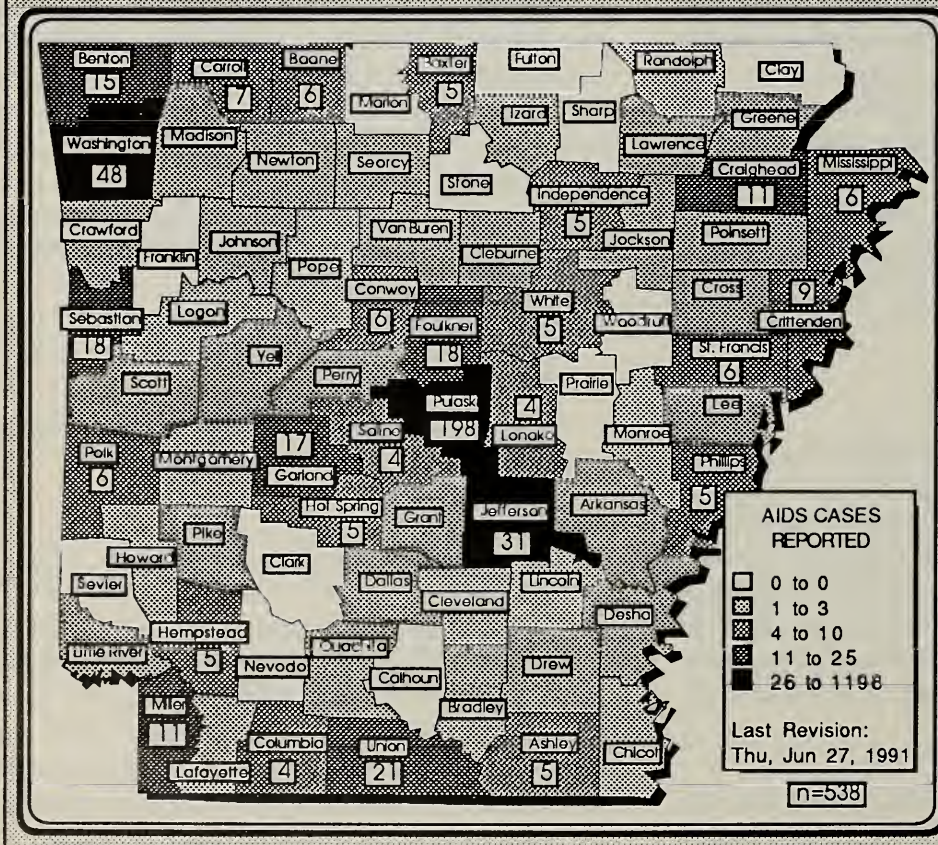
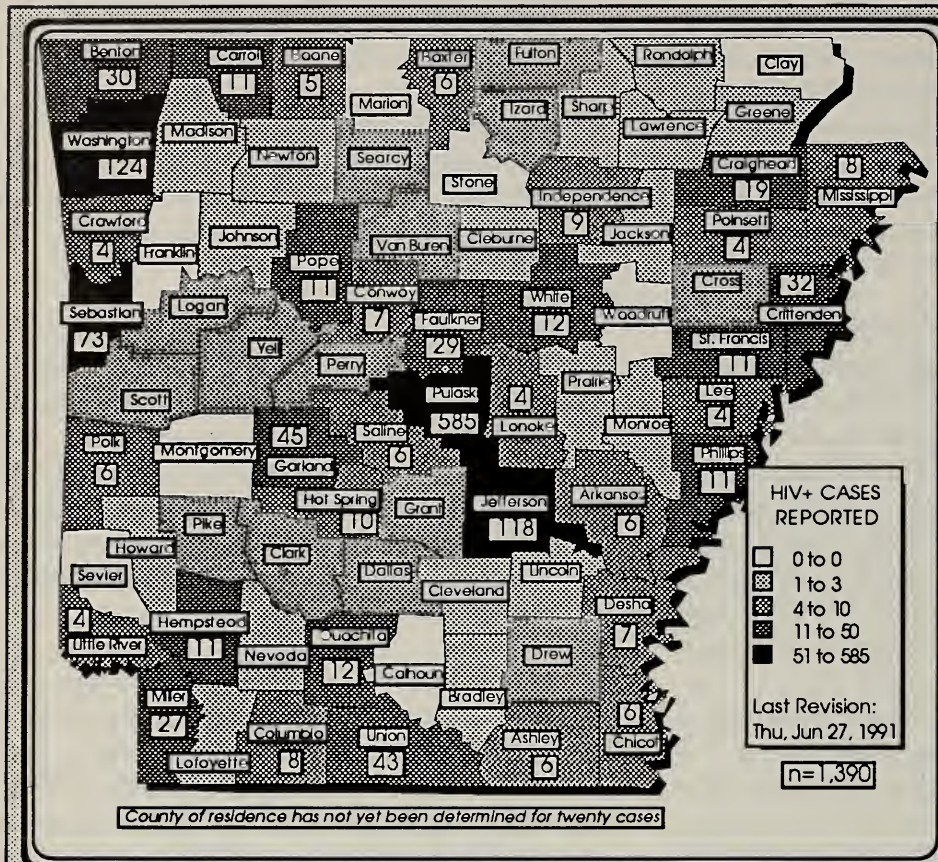
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*The author would like to thank Mr. Douglas R. Murray, director of the Arkansas Department of Health's Center for Health Statistics, for making the Arkansas birth data readily accessible.*



# Arkansas HIV/AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statutes 20-15-904, 15-14-123, 16-82-101 and Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of: Nursing Homes, Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

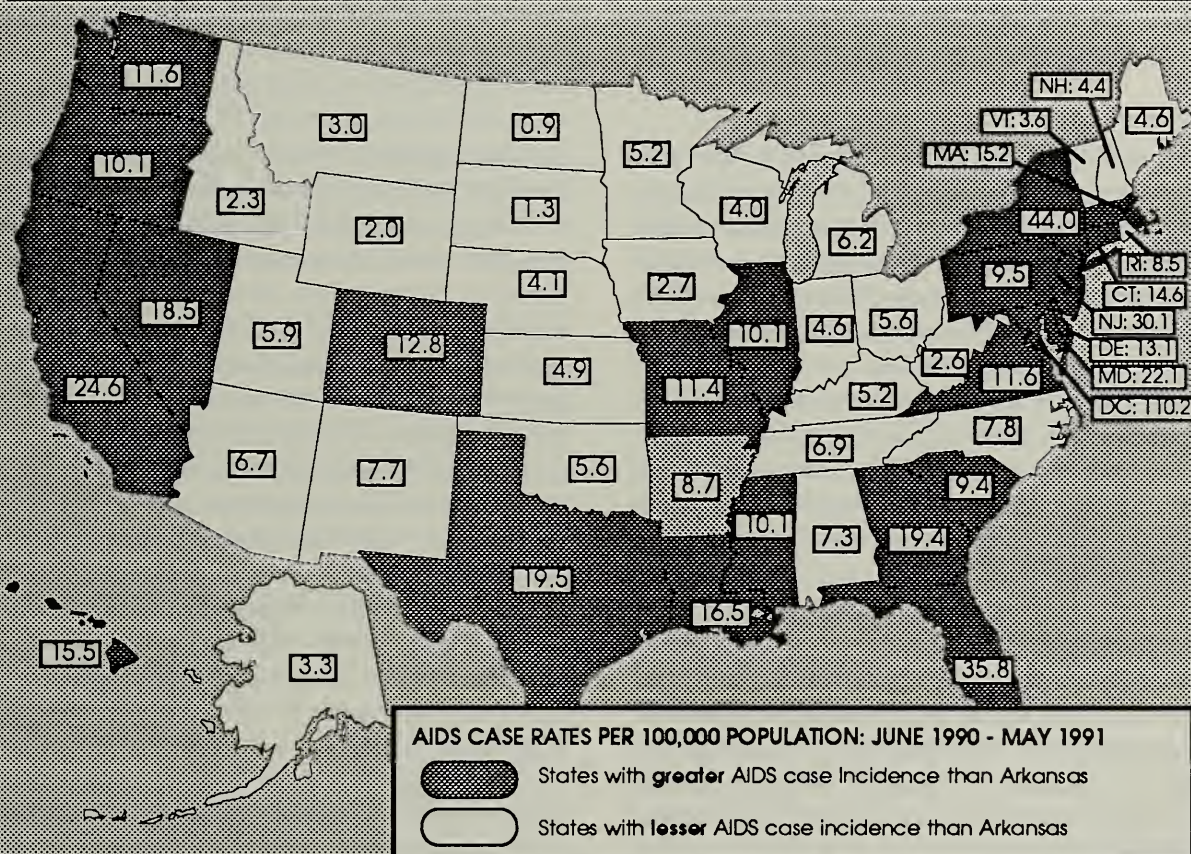
Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# Arkansas AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: JUNE '90 - MAY '91	205	Reported: JUNE '90 - MAY '91	42,934
Rates per 100,000 population: JUN '90 - MAY '91	8.7	Rates per 100,000 population: JUN '90 - MAY '91	17.0
Cumulative Reports: 1983 - JUNE '91	538	Cumulative Reports: 1980 - MAY '91	179,136
Adult	524	Adult	176,047
Pediatric	14	Pediatric	3,089
Deaths: 1983 - JUNE '91	305	Deaths: 1980 - MAY '91	113,426
Adult	299	Adult	111,815
Pediatric	6	Pediatric	1,611
Mortality Rate	56.7%	Mortality Rate	63.3%



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	62.8%	Gay or Bisexual Men	57.9%
Heterosexual IV Drug Users	11.0%	Heterosexual IV Drug Users	21.8%
Gay or Bisexual Men who used IV Drugs	9.5%	Gay or Bisexual Men who used IV Drugs	6.5%
Heterosexual contact with person at risk	5.6%	Heterosexual contact with person at risk	5.4%
Transfusion with blood products	3.9%	Transfusion with blood products	2.4%
Perinatal	1.9%	Perinatal	1.5%
Hemophilia	1.7%	Hemophilia	0.9%
Risk unknown at this time	3.5%	Risk unknown at this time	3.7%



## Use of Hematopoietic Growth Factors in Patients with HIV Disease

Infection with HIV has grave consequences for every organ and tissue in the body, not the least of which is the bone marrow. The cause of hematopoietic abnormalities in HIV infection is multifactorial and includes defects in normal hematopoiesis, peripheral destruction of blood cells, direct myelosuppression by drugs, and suppressive effects of opportunistic infections and malignancies.

Our most effective drugs are also the most myelosuppressive ones and include Zidovudine, Pentamidine, Ganciclovir, and Trimethoprim/Sulfa. In addition, prolonged survival in HIV disease carries an increased risk of AIDS related non-Hodgkin's lymphoma, the treatment of which depends on severely myelosuppressive drug regimens.

A number of functional abnormalities of leukocytes have also been documented in patients with advanced HIV disease and may contribute to the high incidence of infections in these patients, especially *Hemophilus influenzae*, *Streptococcus pneumoniae*, and *Pseudomonas aeruginosa*. Anemia and leukopenia are common findings in patients with HIV disease and are major dose limiting factors in our ability to treat these patients.

In the past two years, the hematopoietic growth factors have made a dramatic entrance into clinical trials in humans, both for advanced malignancy and AIDS. G-CSF (granulocyte colony stimulating factor), GM-CSF (granulocyte-macrophage colony stimulating factor) and recombinant erythropoietin (EPO) will be addressed here.

C-CSF and GM-CSF are naturally occurring cytokine glycoproteins that stimulate proliferation, differentiation and functional activity of neutrophils, and in the case of GM-CSF, monocytes and macrophages. The gene for G-CSF is located on Chromosome 17. It is produced by fibroblasts and endothelial cells in response to tumor necrosis factor, Interleukin II and certain bacteria. It stimulates the proliferation

and maturation of myeloid progenitor cells and enhances selected functions of mature neutrophils as well.

The gene for GM-CSF is located on Chromosome 5. It is highly active 127 amino-acid glycoprotein which is produced by lymphocytes, fibroblasts, activated macrophages and by a variety of cells of diverse embryologic origin. No cell has been found that steadily produces it in vivo, and its proposed role in human hematopoiesis is that of an emergency response. Of note is that in clinical trials one patient given GM-CSF daily for one month lost responsiveness. No patient has lost responsiveness when given GM-CSF in two week pulses. GM-CSF prepares neutrophils for killing by inhibiting random migration, increasing chemotaxis, and increasing adhesion, phagocytosis and superoxide generation. The neutrophils show toxic granulations, Doehle bodies and cytoplasmic vacuolization similar to the appearance of neutrophils in sepsis. It also increases eosinophil cytotoxicity for parasites.

Given subcutaneously or IV to normal volunteers, both cause a rapid rise in white blood cells, within two or three days. Leukocytosis also occurs in patients with impaired marrow reserve, but usually only after seven to 14 days of treatment, and counts return to baseline levels usually within seven days.

The first major clinical trial examining the effect of GM-CSF was done by Groopman et al, in 1987. This phase one study in patients with end-stage HIV disease documented a rapid and dose related increase in leukocytes, and increase in total marrow cellularity in 11 of 14 patients and correction of neutrophil dysfunction in several patients. Although neither enhanced HIV recovery or elevated P24 levels were found in this study, others have noted apparent enhancement of viral production with GM-CSF administration.

GM-CSF has also been shown to ameliorate Zidovudine



induced neutropenia. In a study by Levine et al, patients with AIDS or ARC with neutrophil counts less than 1000/mm<sup>3</sup> while taking Zidovudine 1200 mg/day responded to GM-CSF with increases in their neutrophil counts without increase of HIV expression in either cocultures of peripheral blood mononuclear cells or by elevated serum P24 antigen levels. Toxicities were generally mild and consisted of fatigue, asthenia, erythema at the injection site. Other investigators have noted eosinophilia, skin rashes and fever with GM-CSF, but not G-CSF. From this data, it appears that G-CSF and GM-CSF are effective in both the neutropenia associated with HIV infection itself, as well as Zidovudine induced neutropenia.

Other clinical trials have studied ganciclovir induced leukopenia in patients with severe CMV infections. This virus is a major cause of morbidity in AIDS patients, causing retinitis, pneumonia, and colitis. Ganciclovir is an effective antiviral drug for the treatment of CMV but induces significant myelosuppression. When GM-CSF was administered to seventeen patients with progressive CMV retinitis and leukopenic intolerance to ganciclovir (neutrophil count less than 500), ganciclovir could be continued at full doses. No viral resistance to ganciclovir was observed and the regimen appeared to prevent progression of retinitis in all patients. In addition, a majority of patients were also able to continue treatment with Zidovudine concurrently with ganciclovir.

Another potential use for both G-CSF and GM-CSF is in the area of chemotherapy induced neutropenia. A recent study by Kaplan et al, in the *Journal of Clinical Oncology* examines the effects of GM-CSF given after standard dose chemotherapy for AIDS related lymphoma. Current state-of-the-art therapy for this malignancy utilizes low dose chemotherapy without concurrent Zidovudine to avoid life threatening neutropenia and sepsis. The Kaplan study utilized fairly standard CHOP-methotrexate with GM-CSF beginning at various schedules after chemotherapy. In the most effective schedule, GM-CSF was begun on day four of each chemotherapy cycle and continued until day 13. Compared with the control group, the GM-CSF group had higher mean nadirs of the absolute neutrophil count, shorter mean durations of neutropenia, fewer chemotherapy cycles complicated by neutropenia and fever, fewer days hospitalized for fever and neutropenia, fewer reductions in chemotherapy dosages and less frequent delays in chemotherapy administration. Of note is that serum P24 antigen levels decreased to 18% of baseline in the control group (probably due to the lymphocytopathic effect of chemotherapy), but increased to 243% of baseline in the GM-CSF group, suggesting stimulation of HIV replication. The effect of this change in HIV activity on clinical outcome of treated patients could not be determined, and therefore the clinical significance of this finding remains unclear. Complete response rates and survival times were identical. In summary, administration of GM-CSF reduced chemotherapy associated myelosuppression and its morbidity without affecting survival. The

question of total cost of care was not addressed, but each 10-day course of GM-CSF costs \$1200-\$1500.

## Erythropoietin

The gene for erythropoietin is located on Chromosome 7 and is both constitutively expressed and inducible. It is a 166 amino acid protein produced in the peritubular interstitial cells of the kidney in response to local tissue hypoxia. The earliest and most extensive clinical experience with recombinant erythropoietin has been in patients with renal failure, in who it almost universally produces a dose-dependent increase in hemoglobin. Reticulocytes increase by the second or third dose and the hemoglobin follows, usually by the second week.

These early studies have shown that approximately 43% of patients on the drug develop iron deficiency due to inadequate or insufficiently rapid release of iron from reticuloendothelial stores which diminishes the erythroid response to erythropoietin. Oral iron therapy should be started if the iron/TIBC ratio is less than 20%.

Anemia, either as a result of HIV infection or as result of Zidovudine therapy is quite common in patients with AIDS, occurring with an estimated frequency of 50-75%, depending on severity of disease and dosage of Zidovudine. Endogenous erythropoietin levels in patients with HIV related anemia are generally less than expected for any given level of anemia and hence parallel the situation seen in the anemia of chronic disease. In a randomized double blind, placebo-controlled multicenter trial of recombinant erythropoietin, 63 patients with AIDS receiving Zidovudine with baseline HCT's less than 30% were randomized to receive either placebo or EPO subcutaneously three times weekly. Patients were retrospectively stratified according to entry level endogenous serum erythropoietin levels. Patients with native erythropoietin levels less than 500 IU/L experienced a statistically significant decrease in the mean number of units of blood transfused after six weeks of EPO administration. There was no difference in transfusion requirements between controls and those patients with native erythropoietin levels greater than 500 IU/L. Recombinant erythropoietin, in selected patients with adequate iron stores, can significantly ameliorate the anemia induced by Zidovudine.

Colony Stimulating Factors have earned an important place in the present and future management of HIV infection and the complications of AIDS and related therapies. Erythropoietin, G-CSF and GM-CSF have been licensed for use in the U.S. and are available now. CSF's have been shown to be biologically active in persons in HIV disease and Phase I and II trials have demonstrated efficacy with a relatively minor toxicity profile. Subcutaneous administration has allowed for convenience of administration in the outpatient setting. Although their high cost is a relative drawback to their widespread use, they represent major advances in the battle against AIDS, and their use in carefully selected patients represents state-of-the-art care.



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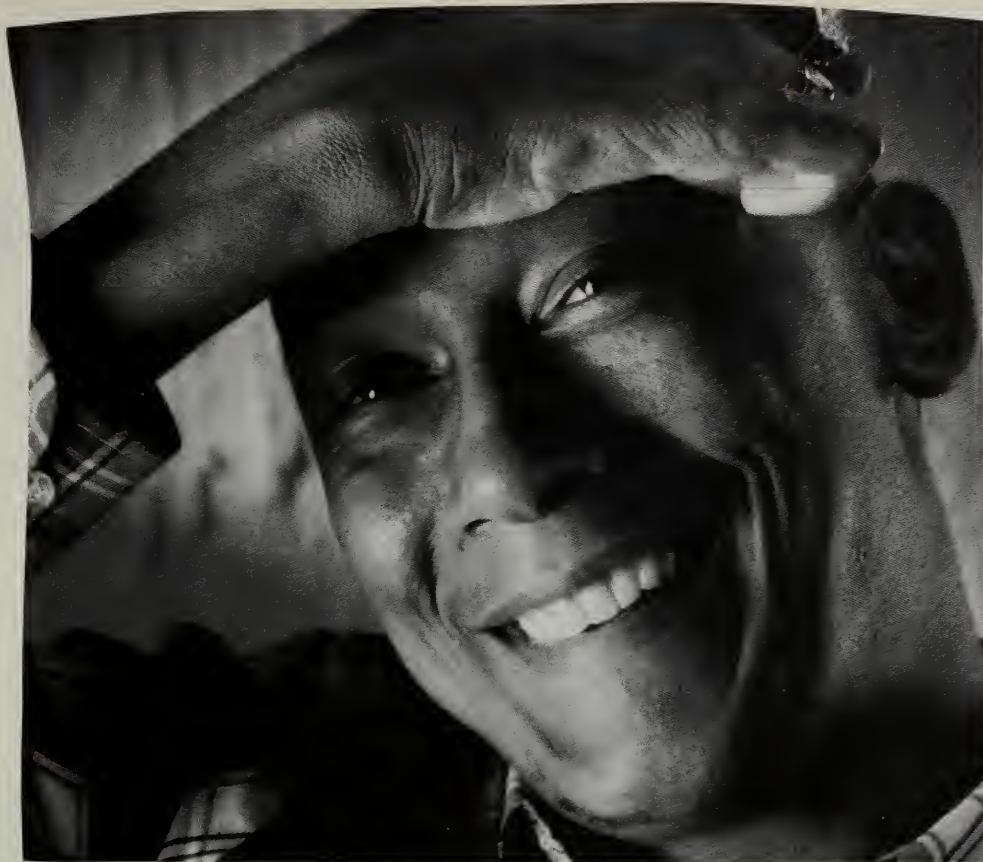
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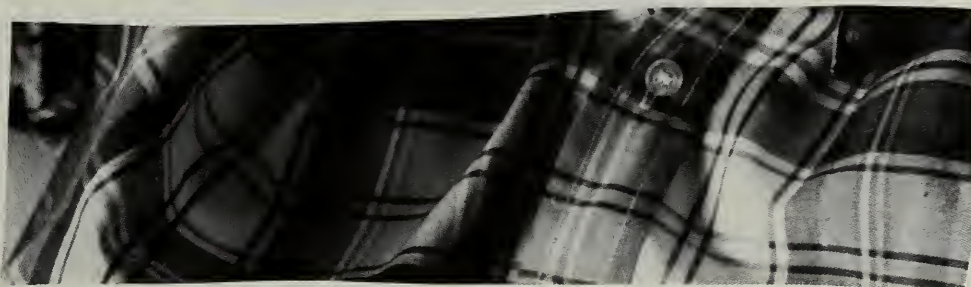
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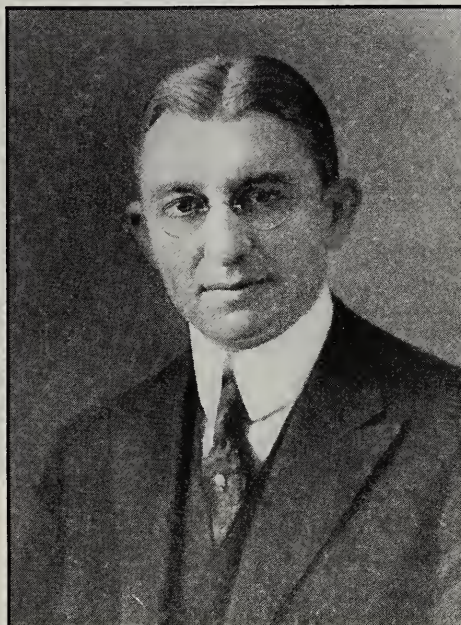


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# James Issac Scarborough, M.D.



Edwina Walls, M.L.S.\*

James Issac Scarborough was a native of Kosciusko, Mississippi, born on August 26, 1880, the son of Judge and Mrs. Otis W. Scarborough. In 1904, he earned an undergraduate degree from Princeton University<sup>1</sup> where he studied under such scholars as Woodrow Wilson and Henry Van Dyke.<sup>2</sup> His medical education was completed at Johns Hopkins University in 1908. He served on the staff of the Mayo Clinic for a two year period and for part of that time was an assistant to Dr. William J. May, one of the founders of the Clinic. He was a fellow in surgery at the Clinic and served as president of the Resident and Non-resident Physicians of the Clinic.<sup>3</sup>

Dr. Scarborough was described as personifying the ideal of the professional man as gentleman and scholar. He was a mentor for numerous young physicians in Arkansas.<sup>4</sup>

Dr. Scarborough practiced at Trinity Hospital in Little Rock from its beginning in 1924 until his retirement. He was one of the two physicians at Trinity whose specialty was surgery. His area of special interest was gastrointestinal surgery. When he came to Trinity to practice, he had had 10 years of residency in surgery — five years at Johns Hopkins and five years at the Mayo Clinic. He was a master technician of surgical procedures, and he was known to have said that if he had published his statistics of successful thyroid surgery, a still complicated procedure then, that nobody would have believed him.<sup>5</sup> In 1921, Dr. Scarborough served as chief of staff of St. Vincents Infirmary.<sup>6</sup>

Dr. Scarborough was married to Mary Roberta Carter at

Baltimore, Maryland, on March 16, 1916. The couple had one son.

An indication of the respect and high regard in which Dr. Scarborough was held by his professional associates is shown by his acceptance as the first member to rejoin the Pulaski County Medical Society after the years of the

Trinity Hospital controversy. He was unanimously elected to membership on June 3, 1946, while all other applications of Trinity Hospital staff were rejected even six months later.<sup>7</sup>

Dr. Scarborough retired about 10 years prior to his death. His death occurred at his home on October 29, 1957, of emphysema and cor pulmonale.<sup>8</sup>

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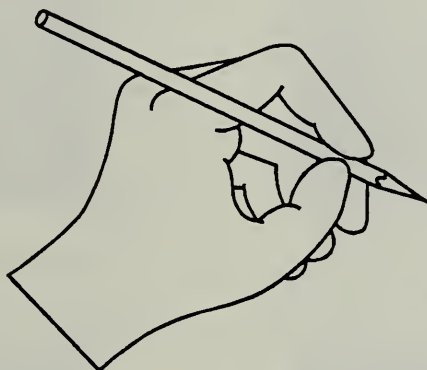
\* Ms. Walls is the head of the Special Collections department of the University of Arkansas for Medical Sciences at Little Rock, Arkansas.

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**Ewart, David V.**, Internal Medicine, Siloam Springs. Born, November 16, 1959, Tahlequah, OK. Medical education, University of Oklahoma College of Medicine, Tulsa, 1985. Internship/residency, Tulane University Affiliated Hospitals, 1989. Practice experience, 2 years. Board certified.

**Mertz, John D.**, Orthopaedic Surgery, Rogers. Born, April 9, 1950, Roanoke, VA. Medical education, University of Texas Southwestern, Dallas, 1980. Internship/residency, UAMS, 1985. Practice experience, 5 years. Board certified.

## PULASKI COUNTY

**Alexander, Albert S.**, Radiology, Little Rock. Born, January 26, 1960, Little Rock. Medical education, UAMS, 1986. Internship/residency, University of Texas Southwest Medical School, 1990. Board certified.

**Benton, William H.**, Pediatrics/Neonatology, Little Rock. Born, December 8, 1958, Baton Rouge, LA. Medical education, LSU Medical Center, Shreveport, 1985. Internship/residency, LSU Medical Center, Shreveport, 1990.

**Hayes, John M.**, General Vascular & Thoracic Surgery, North Little Rock. Born, February 3, 1960, Worcester, MA. Medical education, Boston University, MA, 1986. Internship/residency, Waterbury Hospital, CT, 1991. Pending certification.

**Meadors, Frederick A.**, Cardiothoracic & Peripheral Vascular Surgery, Little Rock. Born, June 5, 1957, Little Rock. Medical education, UAMS, 1983. Internship/residency, Baylor College of Medicine Affiliated Hospitals, Houston, TX, 1990. Board certified.

**Pevahouse, Joe B.**, Nephrology, Little Rock. Born, September 12, 1956, Jackson, TN. Medical education, Vanderbilt University School of Medicine, Nashville, TN, 1982. Internship/residency, UAMS, 1989. Practice experience, 1 year. Board certified.

**Phillips, Hannah M.**, Psychiatry, Little Rock. Born, May 8, 1940, Jonesboro. Medical education, UAMS, 1986. Internship/residency, UAMS, 1990.

**Pickett, Karen P.**, Family Practice, Little Rock. Born, December 22, 1954, Pocahontas. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991.

**Talbert, Michael L.**, Radiation Oncology, Little Rock. Born, June 13, 1959, Baton Rouge, LA. Medical education, UAMS, 1985. Internship, UAMS, 1986. Residency, M.D. Anderson Cancer Center, Houston, TX, 1991. Board certified.

**Weiss, David W.**, Radiology & Nuclear Medicine, Little Rock. Born March 16, 1958, Dallas, TX. Medical education, University of Texas Medical Branch, Galveston, 1984. Internship/residency, UAMS, 1989. Board certified.

## SEBASTIAN COUNTY

**Tait, Layre S.**, Anesthesiology, Fort Smith. Born, September 20, 1959, Bartlesville, OK. Medical education, University of Kansas School of Medicine, 1986. Internship/residency, Indiana University School of Medicine, 1990. Pending certification.

## RESIDENT

**Davidson, Charles D.**, Family Practice. Born, June 18, 1959, Walnut Ridge. Medical education, UAMS, 1991. Residency, Naval Hospital, Jacksonville, FL.

**Davis, Brett C.**, Internal Medicine & Geriatrics. Born, December 17, 1956, Monticello. Medical education, UAMS, 1984. Internship/residency/fellowship, UAMS.

**Henderson, Vickie L.** Born, August 25, 1964, Benton. Medical education, UAMS, 1991. Internship, UAMS.

**Ziegler, Robert H.**, Internal Medicine. Born, November 8, 1964, El Dorado. Medical education, UAMS, 1991. Residency, UAMS.

## STUDENTS

McGarry, Pat G.

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# Radiological Case of the Month

Kenneth V. Robbins, M.D.  
William J. Morton, M.D.  
David L. Harshfield, M.D.  
Steven R. Nokes, M.D.

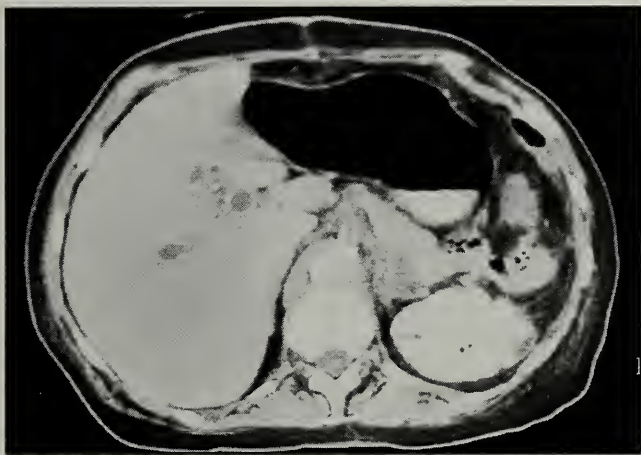
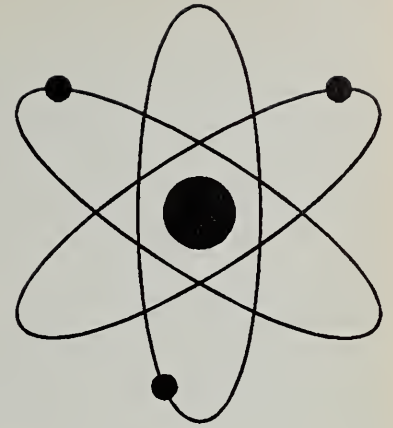


Figure 1. CT scan of the abdomen.

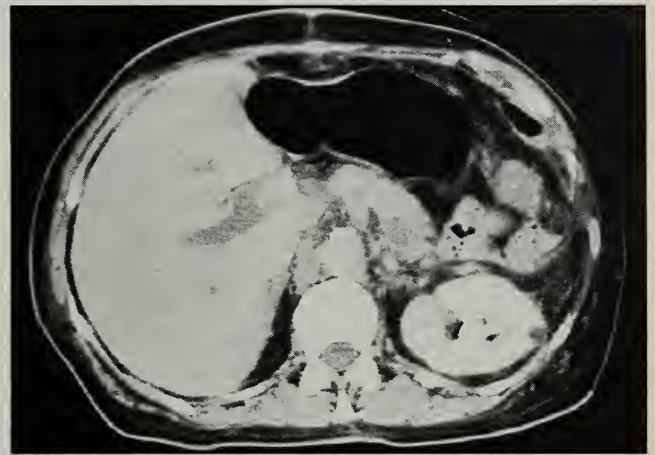


Figure 2. CT scan of the abdomen.

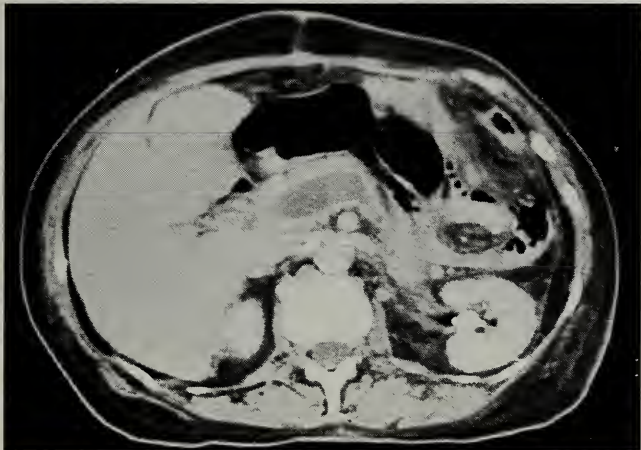


Figure 3. CT scan of the abdomen.

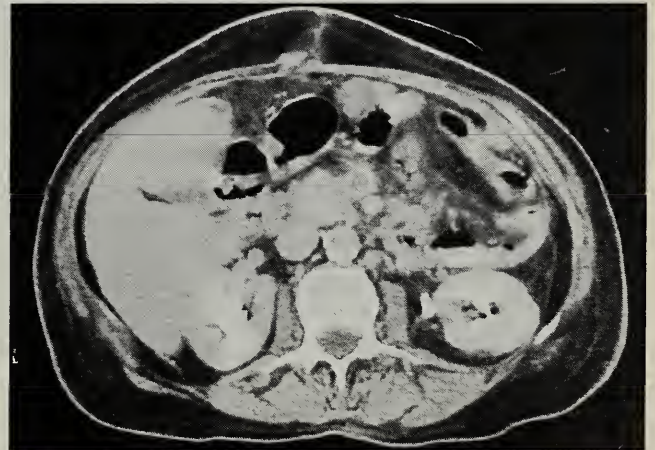


Figure 4. CT scan of the abdomen.

## History:

This 75 year-old white female was referred for evaluation of persistent left upper quadrant pain and nausea. Prior to referral, the patient had undergone an exploratory laparotomy and was found to have a splenic infarct for which a splenectomy was performed. Admission lab demonstrated a leukocytosis (WBC 17.1) with the remainder of the admission lab including liver function tests, platelet count and amylase being unremarkable. An abdominal CT scan was obtained as part of the workup.



---

## Portal and Superior Mesenteric Venous Thrombosis

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### Radiographic Findings:

CT scan of the abdomen with IV contrast reveals surgical absence of the spleen and an intraluminal decreased density within the main portal vein and rim enhancement (Figure 1), an intraluminal decreased density within the right portal vein and splenic vein (Figure 2), an intraluminal decreased density within the confluence of the splenic and superior mesenteric veins (Figure 3), and an intraluminal decreased density within the superior mesenteric vein and rim enhancement (Figure 4).

### Discussion:

Portal vein thrombosis is encountered primarily in patients with cirrhosis with or without hepatocellular carcinoma, pancreatic disease, thrombocythemia, ascending cholangitis, or estrogen therapy. Splenectomy seems to be a major factor in development of splenic thrombosis spreading to portal system and this is especially true in patients with a preoperative or immediate postoperative platelet disorder. The most common causes of mesenteric vein occlusion are peritonitis, neoplasm, and abdominal surgery. In the postoperative group, post-splenectomy patients are the most likely to develop superior mesenteric vein thrombosis.

The clinical findings of portal and mesenteric vein occlusion vary and can be acute pain or slow, gradual onset of vague abdominal pain that increases with severity. Low-grade fever and leukocytosis are not uncommon. Hematemesis and melena may occur as early findings.

On dynamic CT portal and superior mesenteric venous thrombosis is characterized by decreased intraluminal density combined with enlarged, sharply defined vessels and ring enhancement due to opacification of arterially supplied vasa vasorum. Thrombosis of the portal vein can be confirmed by lack of doppler signals emanating from the central lumen. Duplex doppler sonography yields information concerning the presence of blood flow, turbulence, and direction of blood flow and can differentiate arterial from venous blood flow.

The extensive venous collateral circulation prevents infarction in most cases of superior mesenteric vein thrombosis. The course of portal thrombosis is usually marked by slow development of collateral pathways (cavernous transformation). Rarely recanalization is achieved with medical management. CT and pulsed doppler duplex sonography are effective methods of confirming the presence and site of thrombus and in addition allows a method of following the course of the disorder.

### References

1. Mathieu D, Vasile N, Grenier P. Portal thrombosis: dynamic CT features and course. *Radiology* 1985; 154:737-41.
2. Rosen A, Korobkin M, Silverman PM, Dunnick NR, Kelvin FM. Mesenteric vein thrombosis: CT identification. *AJR* 1984; 143:83-6.
3. Miller VE, Berland LL. Pulsed doppler duplex sonography and CT of portal vein thrombosis. *AJR* 1985; 147:73-6.

---

*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Kenneth V. Robbins, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: William J. Morton, M.D., is in private practice and is affiliated with the Little Rock Diagnostic Clinic.*

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# AMS Newsmakers

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**Dr. Joycelyn Elders**, director of the Arkansas Health Department, was awarded the ninth annual Candace Award for health sciences. The award honors distinguished achievement among black women.

**Dr. Mark Floyd**, of Murfreesboro, recently received a plaque "In Appreciation of Community Service '91" from Pike County Memorial Hospital in conjunction with "National Health Month."

**Dr. Alvin Scott Hardin**, assistant chief of medicine for the Medical Center of South Arkansas and an assistant professor of medicine and cardiology instructor with the University of Arkansas Family Practice Residency program, has been appointed to the board of directors for the South Arkansas Radiation Therapy Institute in El Dorado.

**Dr. William N. Jones**, AMS immediate past president and original chairman of the AMS Committee on AIDS, recently appeared on the McNeil-Lehrer News Hour television program and on the Family News in Focus national radio program, to discuss HHS Secretary Sullivan's proposed changes in immigration regulations regarding HIV sero-positive individuals. Dr. Jones was also interviewed by both major Arkansas newspapers regarding AIDS testing of health care workers. Dr. Jones has been instrumental in the development of the American Medical Association's Policy on AIDS.

**Dr. Joanna J. Seibert**, a pediatric radiologist and chief of the medical staff at Arkansas Children's Hospital, has been elected president-elect of the Society of Pediatric Radiology of North America.

## Outstanding Practice Opportunity for Family Physician or General Internist

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**Dr. James Y. Suen**, a noted cancer researcher from Little Rock, recently won the Distinguished Citizen award at the 1991 Channel 4 Community Service Awards. Dr. Suen teaches at the University of Arkansas for Medical Sciences and has written three textbooks on cancer of the head and neck.

**Dr. Harry P. Ward**, the chancellor of the University of Arkansas for Medical Sciences, recently received an honorary degree of doctor of science from the Kaohsiung Medical College and Republic of China in recognition of his outstanding role in medical education, research and healthcare.

**Dr. Hiram Ward**, of Murfreesboro, recently received a plaque "In Appreciation of Community Service '91" from Pike County Memorial Hospital in conjunction with "National Health Month."

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**HolterLab** (hol-ter-lab) High resolution Holter scanner kit. Previously unavailable software allows you to turn your IBM 286 or 386 computer into a powerful Holter system. Kit consists of 12 bit A-D board, laser printer, high-speed cassette drive, software, and installation/training video. This software is used by several large companies to build Holter systems. Add to your computer in just a few hours.

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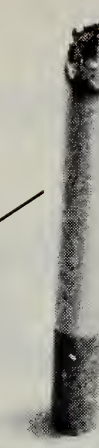
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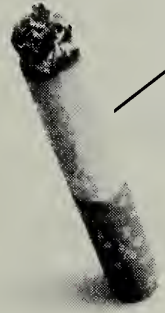
*"Nah,  
I've smoked  
for  
30 years.  
It's too late."*




*"I've tried a  
million times,  
but I just  
can't."*



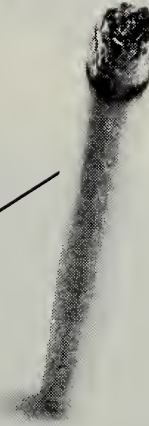
*"I'll  
quit  
next  
week."*




*"What difference does  
it make? I'm already  
52 years old."*




*"I'll quit  
next year."*



*"It's one of the  
few pleasures  
I have left."*



*"I've got  
other things  
to worry about."*



*"The damage  
is done."*

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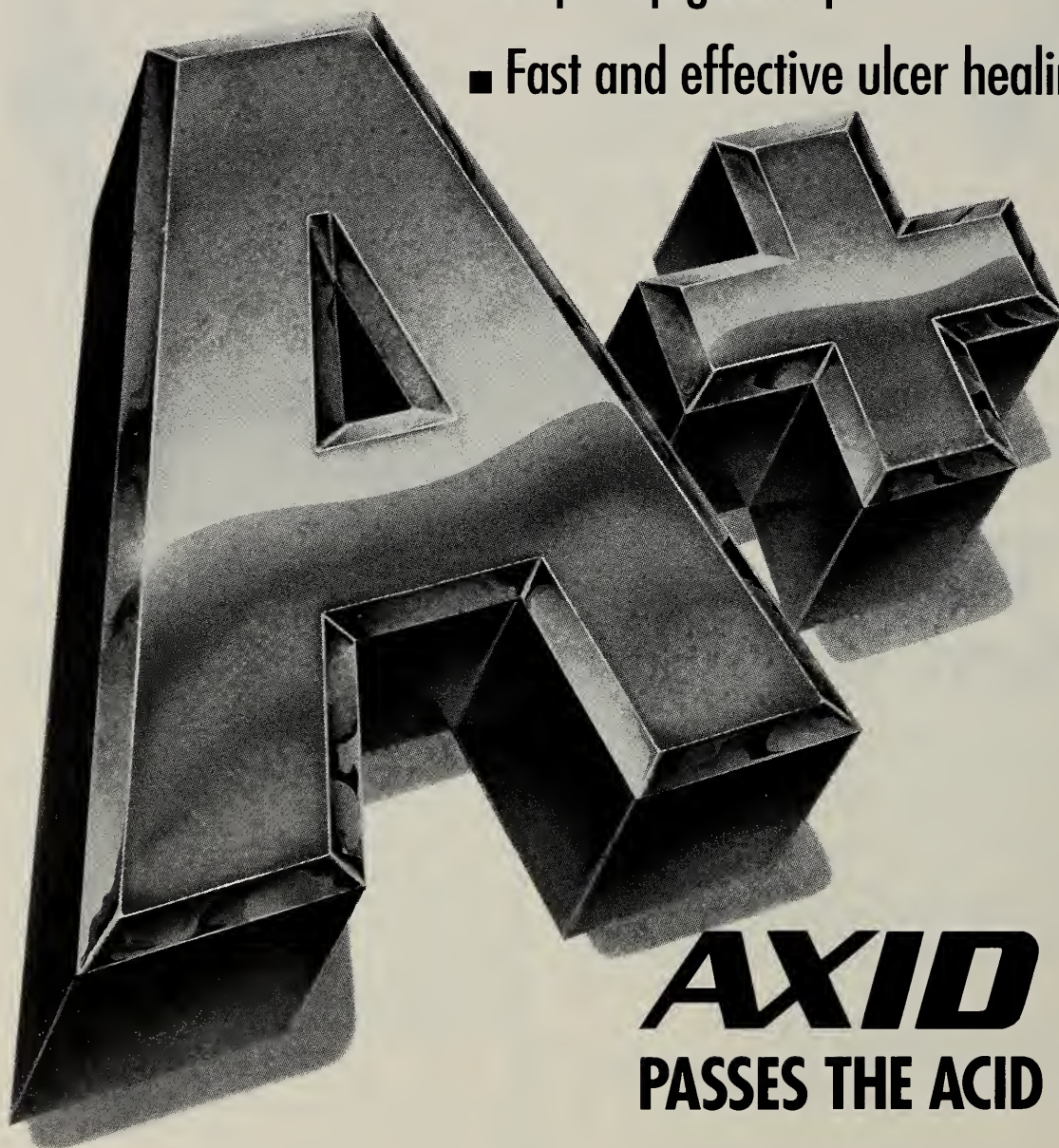


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- Fast and effective ulcer healing<sup>2,3,4</sup>



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\*Most patients experience pain relief with the first dose.  
See adjacent page for references and brief summary  
of prescribing information.



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**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorthalidone, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdose occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP  
(091190)

### References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

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Additional information available to the profession on request.



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# In Memoriam

## Charles C. Ault, M.D.

Charles C. Ault, M.D., of North Little Rock, died Tuesday, June 18, 1991. He was 86.

Dr. Ault was a retired psychiatrist with the Veterans Administration and a member of the Arkansas Medical Society.

Dr. Ault is survived by four sons, B.A. Ault of Clarksdale, MO, Ruey Ault of Lafayette, LA, Charles Ault Jr. of Greenbrier and John Ault of North Little Rock; nine grandchildren; and 11 great-grandchild.

## James H. Fraser Jr., M.D.

James H. Fraser Jr., M.D., a Little Rock obstetrician and gynecologist, died Friday, June 21, 1991. He was 45.

Dr. Fraser was a member of the American Medical Association, Arkansas Medical Society, and the Pulaski County Medical Society.

Dr. Fraser is survived by his wife, Vicki Tackett Fraser of Little Rock; a son, Scott Andrew Fraser of Little Rock; two daughters, Kristi and Paige Fraser of Little Rock; his mother, Mabel Claire Vail Fraser of Little Rock; and a sister, Margaret Fraser Tyler of Conway.

## Mrs. Mary Frances "Chancey" Knight

Mrs. Mary Frances "Chancey" Knight, of Fort Smith, died Monday, June 17, 1991.

Mrs. Knight was a member of the Arkansas Medical Society Auxiliary.

Mrs. Knight is survived by her husband, Dr. William E. Knight; two stepdaughters, Carol Blanchard of Annapolis, MD, and Linda Knight of Springfield, VA; a sister, Grace Vick of Little Rock; three grandchildren; and three great-grandchildren.





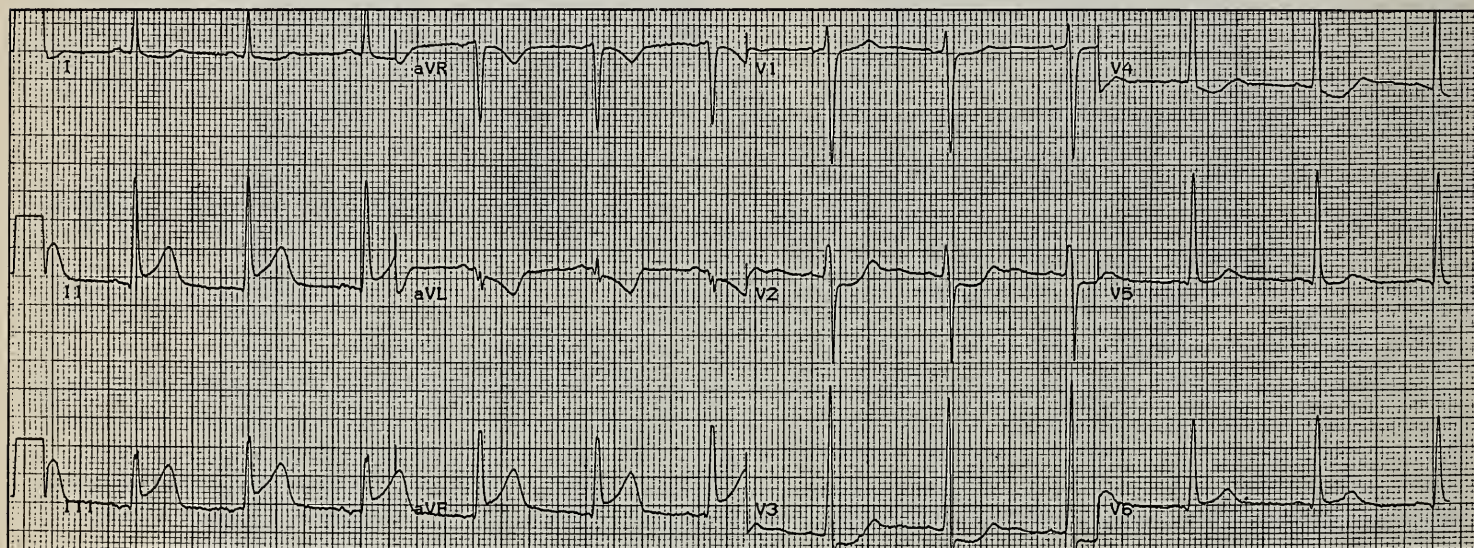


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## CLINICAL HISTORY:

This record was obtained from a 55 year-old male with a long history of hypertension, peptic ulcer disease and gastroesophageal reflux. He had a history of increasing pain, attributed to his reflux, over the past several weeks, culminating in a severe episode of pain occurring one hour prior to presentation to the hospital. On admission to the Emergency Department, this ECG was obtained.



## DISCUSSION:

The rhythm is normal sinus at a rate of 71 beats per minute. The PR interval is 130 msec, the QRS duration is 110 msec and the QT interval is 380 msec. Voltage criteria for left ventricular hypertrophy are present. The most striking abnormality is the marked elevation of the ST-segments in leads II, III, and aVF. This elevation is associated with ST-segment depression in aVL and V2-V4. The inferior leads, facing an area of epicardial injury, register ST-segment elevation whereas the anterior and high lateral leads, facing the endocardial surface of the injured myocardium, register ST-segment depression and are thus reciprocal to the changes overlying the area of injury. Thus, this record depicts **acute inferior injury**. Similar electrocardiographic changes may be observed in response to coronary spasm or transient occlusion of an epicardial coronary artery. In this clinical setting, the most likely cause of these changes is acute myocardial infarction with this record fulfilling electrocardiographic criteria for thrombolytic therapy. However, the electrocardiographic diagnosis of acute myocardial infarction requires evolutionary changes in serial ECGs. Thus, while this ECG is highly suggestive of an acute inferior infarct, particularly in the clinical setting provided, it is properly interpreted as acute inferior injury with the recommendation for that serial ECGs be obtained.

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# Things To Come

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## August 21

**1991 General Loss Prevention Seminar.** Airport Hilton Inn, Memphis, TN. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## August 22

**1991 General Loss Prevention Seminar.** Airport Hilton Inn, Memphis, TN. Sponsored by State Volunteer Mutual Insurance Company. CME credit available. Fee: \$50. For more information, call 800-633-3215.

## October 2-12

**Allergy Abroad.** Hong Kong & Guilin, China. Sponsored by the Division of Allergy and Immunology and the Office of Continuing Medical Education, Washington University School of Medicine in St. Louis, MO. For more information, call (800) 325-9862.

## October 4-5

**1st National Symposium on Day Care for Children.** The Ritz-Carlton, Pentagon City, Arlington, VA. Sponsored by the American Academy of Pediatrics and the Institute for Pediatric Service of Johnson & Johnson Consumer Products, Inc. Category I credits available. Fees: \$250.00, physicians; \$150.00, nurses, allied health professionals, educators; \$100.00 residents, graduate students, others in training. For more information, call Jim Dettre at (908) 874-1631.

## October 13-17

**Joint Meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology.** Anaheim Convention Center, CA. Sponsored by the American Academy of Ophthalmology. For more information, contact Linda Whitfield, (415) 561-8500.

## October 28-31

**Primary Care Update.** Hyatt Regency New Orleans, LA. Sponsored by the Interstate Postgraduate Medical Association of North America. Category I credits available. Fees: \$225, advance registration; \$250, on site registration; \$35, residents & interns; \$50, allied health professionals. For more information, call (608) 257-1401.

## November 7-8

**National Conference on Alcohol & Other Drug Abuse: Changing Lives Through Research & Treatment.** Meharry Medical College, Nashville, TN. Sponsored by the Meharry Medical College. For more information, call (800) 669-1269.

## November 16-19

**SMA's 85th Annual Scientific Assembly.** Georgia World Congress Center & Atlanta Hilton & Towers, Atlanta, GA. Sponsored by the Southern Medical Association. For more information, call (800) 423-4992.

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# Keeping Up

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## **Breast Cancer**

August 20, 7:00 p.m., Education Department, Baxter County Regional Hospital. Sponsored by Baxter County Regional Hospital and presented by Bruce White, M.D. Category I credit offered.

## **The Seasonal Child**

September 17, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building. Sponsored by

Arkansas Children's Hospital. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **The Seasonal Child**

December 3, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building. Sponsored by Arkansas Children's Hospital. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

CME Luncheon, second Friday, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.

### **FAYETTEVILLE - VA MEDICAL CENTER**

Medical Conference (varying topics), third Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, third Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, second Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, first Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, fifth Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, first Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

Interhospital Urology Grand Rounds, first Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Dunkerton/AP&L room. Lunch provided  
Chest Conference, second & fourth Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, first Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
GYN Surgery Cancer Conference, second Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Hematology-Oncology Conference, second Thursday, 12:00 noon, Pathology classroom. Lunch provided  
Cancer Center Team Conference, third Thursday, 12:00 noon. Lunch provided  
Sleep Disorders Case Conference, every other Thursday, Video Production conference room. Lunch provided  
Interdisciplinary AIDS Conference, second Friday, 12:00 noon. Sandwich buffet served

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

Anesthesiology Conference, third Thursday, 7:00 a.m., conference room 1  
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
Pathology Conference, first Tuesday, 3:00 p.m., Pathology Library  
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided  
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided



*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; second & fourth Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, sixth Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*CARTI North Tumor Board Cancer Conference*, second Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, fourth Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, second Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon, UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, third or fourth Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Research Conference*, three Wednesdays a month, 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Ob/Gyn Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, first Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, second, third, fourth, fifth Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, fourth Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, second, third, & fourth Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Tumor Conference*, Tuesdays, 4:00 p.m., VAMC-LR, Pathology conference room

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, first & fourth Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, third Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, second Friday, 12:30 p.m., AHEC-South Arkansas



*Internal Medicine Conference*, first, second & fourth Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, second Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, fourth Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, first, second & third Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, fourth Tuesday, 12:30 p.m., AHEC-South Arkansas

#### **FAYETTEVILLE - AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursday, 7:30 a.m., Washington Regional Medical Center

#### **FORT SMITH - AHEC**

*Good Medicine 1991: Politics & Art*, August 20, 12:30 p.m., Library, Sparks Regional Medical Center  
*PUD/DUD*, August 21, 12:00 noon, 7th floor dining room, Sparks Regional Medical Center  
*Practice Management*, August 30, 12:30 p.m. Library, Sparks Regional Medical Center  
*Neuroradiology Conference*, third Wednesday, 12:00 noon, St. Edward Mercy Medical Center

#### **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, first & third Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, second Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, first Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, second Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, fourth & fifth Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, third Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, third Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, second Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro

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*Perinatal Conference*, second Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, third Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, third & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## PINE BLUFF-AHEC

*Behavioral Science Conference*, first & third Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, second & fourth Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, first & fourth Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, third Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, second & fourth Wednesday, 12:00 noon, Jefferson Regional Medical Center  
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*Pediatric Conference*, third Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, third Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, fourth Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, first Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, first Wednesday, 12:00 noon, Jefferson Regional Medical Center

## TEXARKANA-AHEC SOUTHWEST

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, third Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, second Tuesday, 12:00 noon, alternates from St. Michael Hospital to Wadley Regional Medical Center  
*Neuro-Radiology Conference*, second & fourth Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, second Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, first Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st - 4th Friday each month, 12:00 noon, alternates from Wadley Regional Medical Center to St. Michael Hospital



## Advertisers Index

*Advertising Agencies in italics*

American Medical Association .....	157
American Physicians Insurance Exchange .....	inside front
<i>McNabb/DeSoto &amp; Company</i>	
Arkansas Express Claims .....	159
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Collom & Carney Clinic Association .....	144
CompuMedics, Inc. ....	152
Eli Lilly & Company .....	154
<i>Garrison, Jasper, Rose &amp; Company</i>	
Eli Lilly & Company .....	155
Tommy Farrell Associates .....	121
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	163
Freemyer Billing Service .....	121
I CARE of Arkansas .....	back cover
Medical Protective Company .....	134
<i>Ferguson Advertising, Inc.</i>	
Medical Protective Company .....	151
Mediquik Walk-In Clinics .....	133
MEDX .....	125
Mississippi Methodist Rehab Center .....	145
National Heart, Lung & Blood Institute .....	153
Radiology Consultants .....	129
Rather, Beyer & Harper .....	125
State Volunteer Mutual Insurance Company .....	122
<i>The Maryland Group</i>	
U.S. Air Force .....	126
<i>Bozell, Inc.</i>	
University Cardiothoracic Surgery .....	121

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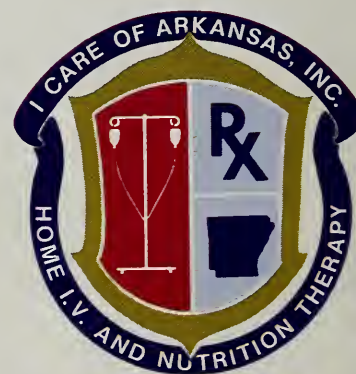
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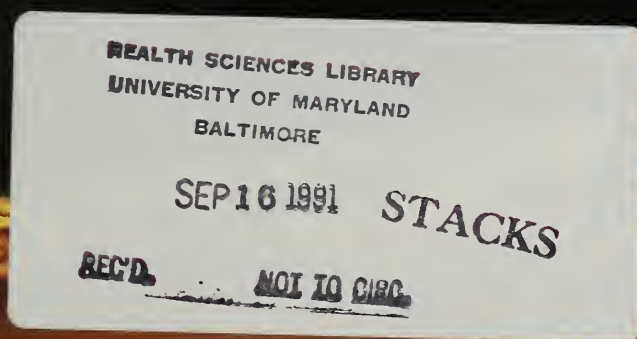
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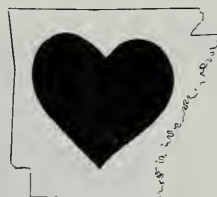
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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 4

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## CONTENTS

### FEATURES

- |     |  |
|-----|--|
| 168 | <b>Health "Networking"</b><br><i>Editorial</i><br>Ben N. Saltzman, M.D.  |
| 171 | <b>Anxiety Disorders: Diagnosis and Treatment</b><br>James "Kurt" Dilday, M.D.   |
| 175 | <b>Efficacy of Dextran Therapy<br/>in Coronary Angioplasty</b><br>Mark H. Bowles, M.D., F.A.C. S.                          |
| 178 | <b>Where Have All The Patients Gone?</b>   |
| 183 | <b>Changes in Society Have Affected the Relationship<br/>Between Physicians and Their Patients</b><br>Mr. Robert J. Miller |

### DEPARTMENTS

- |     |                                       |
|-----|---------------------------------------|
| 186 | <b>AIDS in Arkansas Statistics</b>    |
| 188 | <b>New Members</b>                    |
| 191 | <b>Radiological Case of the Month</b> |
| 194 | <b>AMS Newsmakers</b>                 |
| 197 | <b>In Memoriam</b>                    |
| 198 | <b>Medicine in the News</b>           |
| 200 | <b>ECG of the Month</b>               |
| 202 | <b>Things to Come</b>                 |
| 204 | <b>Keeping Up</b>                     |

Cover photo by A.C. Haralson of the Arkansas Department of Parks & Tourism.



# Health "Networking"

Ben N. Saltzman, M.D.

As I opened the August issue of the *American Journal of Public Health*, I was confronted on the first page with a circular, global, representation of the Western Hemisphere. Superimposed on this background was the following message: "World hunger, environmental pollution, population control, water safety, toxic wastes, teen pregnancy, substance abuse, the spread of AIDS, the health care crisis, child abuse, the homeless, cancer prevention, the mental health crisis, healthcare for the uninsured, human rights, child health in developing countries, home health care, malnutrition, infant mortality, sexually transmitted diseases, world hunger, environmental pollution, population control, water safety, toxic wastes, teen pregnancy, substance abuse," and repetition of the same until the segment of the globe was covered by these words. Under this depiction was the sentence, "Just a few of the problems our graduates will attempt to solve this year."

This was part of a full page advertisement of the Columbia University School of Public Health, inviting applicants to take courses leading to various degrees in Public Health. Actually, it was a challenge to help alleviate some of the ills that beset us today.

In Atlanta, Georgia, November 10-14, 1991, "This year, more than 1,200 scientific and special sessions, workshops, films, poster sessions, award lectures, exhibits, and special events will be open to both American Public Health and World Federation of Public Health Associations registrants." Every aspect of health will be under discussion. It will be an eye-opening experience.

As physicians, we are confronted with the aforementioned problems almost on a daily basis, whether in private practice or in public health. As residents of planet earth, we are told of the problems over and over again; in the media, in

our civic clubs, in our conversations, and in our homes. The remarkable thing is that we are learning to deal with them. Of course we don't have all the solutions, but we find that we are able to educate our patients and the public in general about the problems and point out the possibilities.

The public today is better informed than at any other time in history. Despite this, there is reluctance to follow the guidance we offer. The answer is - more education. We must educate for prevention. We must prevent disease and disease and injury. We cannot survive on treatment alone. We do not have the financial or manpower resources to meet the demands.

As a rural practitioner, it was the public health nurse who introduced me to the community; who acquainted me with the resources available; who provided me with home health care for my home-bound patients; and, who helped me hook up with the human and social service facilities of my community for the benefit of many of my patients.

My experience in public health has made me more aware of the challenges that confront me as a physician. I have learned that without the help of well trained health workers, I would be completely ineffectual. We hear the term "networking" often repeated. In the health field, there must be closer affiliation between the physician in practice and the people in public health. It has long been a neglected resource for the provision of good health care, both preventive and curative.

Arkansas is fortunate in that it is one of the few states that has a cohesive single State Department of Health, encompassing city and county Units, all operating under a central organization in the capitol city.

I urge all practicing physicians to become better acquainted with what we have on a personal basis and make the term "networking" truly meaningful.

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# Anxiety Disorders: Diagnosis and Treatment

## How to Prevent Complications of Benzodiazepine Dependency and Withdrawal

James "Kurt" Dilday, M.D.\*

In recent years, heightened awareness about the excessive morbidity from untreated non-psychotic psychiatric disorders has reached the attention of every practitioner of general medicine in this country. With the introduction of chlordiazepoxide (Librium) and diazepam (Valium) in the 1960s, effective treatment for syndromal anxiety disorders and anxious psychopathology become available but with this advance came complications well known to medicine, consisting of benzodiazepine dependency and withdrawal. The focus of this article will be to elucidate effective diagnostic paradigms and treatment plans for anxiety disordered patient populations.

Psychiatric nosology, though still primitive, does allow physicians to make reasonably valid and reliable diagnoses at the present time. The Diagnostic and Statistical Manual III-R, published by the American Psychiatric Association in 1987, defines psychiatric illnesses in a medical model fashion and promotes a systematic description of these disorders along such familiar medical parameters as clinical symptoms, age at onset, course of illness, prevalence, sex ratio, family history (i.e. genetic vulnerability), and differential diagnosis.<sup>1</sup>

The first job of the physician is to take a history of any anxious patient, including a past medical history, current medications, family history, previous psychiatric diagnosis and treatment, and current state of psychopathology experienced by the patient. This article will focus on two diagnostic categories from the broader area of anxiety disorders under the current nomenclature used in general psychiatry. To diagnose panic disorder, certain features must be present.

### *Criterion A*

At some time during the illness, one or more panic attacks have occurred that were unexpected, i.e. that did not occur immediately before or on exposure to a situation that almost always causes anxiety; and not triggered by situations in which the person was the focus of others' attention. A panic attack is defined as discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During the attacks, there are such symptoms as dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of going crazy or losing control.

### *Criterion B*

Either four attacks have occurred within a four week period or one or more attacks have been followed by a period of at least a month of persistent fear of having another attack.

### *Criterion C*

At least four of the following symptoms developed during at least one of the panic attacks:

- \* Shortness of breath or smothering sensations
- \* Dizziness, unsteady feelings, or fatigue
- \* Palpitations or accelerated heart rate (tachycardia)
- \* Trembling or shaking
- \* Sweating
- \* Choking
- \* Nausea or abdominal distress
- \* Depersonalization or derealization
- \* Numbness or tingling sensations
- \* Flashes or chills
- \* Chest pain or discomfort
- \* Fear of dying
- \* Fear of going crazy or of doing something uncontrolled

---

\* Dr. Dilday is the section chief, Unit 2, of the Arkansas State Hospital in Little Rock and is in private practice at Charter Hospital of Little Rock. Dr. Dilday is a graduate of the University of Arkansas College of Medicine and completed psychiatric residency training at the University of Tennessee College of Medicine in Memphis.



#### *Criterion D*

During at least some of the attacks, at least four of the C symptoms develop suddenly and increased in intensity within ten minutes at the beginning of the first symptom noticed in the attack.

#### *Criterion E*

It cannot be established that an organic factor initiated and maintained the disturbance such as amphetamine or caffeine intoxication or hyperthyroidism.<sup>1</sup>

The diagnostic criteria for generalized anxiety disorder are as follows:

#### *Criterion A*

Unrealistic or excessive anxiety and worry about two or more circumstances, such as worry about possible misfortune to one's child who is in no danger, and worry about finances (for no good reason) for a period of six months or longer, during which the person has been bothered more days than not by these concerns. In children and adolescents this may take the form of anxiety and worry about academic, athletic, and social performance.

#### *Criterion B*

If another Axis I disorder is present, the focus of the anxiety and worry in Criterion A is unrelated to it, e.g. the anxiety or worry is not about having a panic attack [i.e. panic disorder], being embarrassed in public [i.e. social phobia], being contaminated [i.e. obsessive compulsive disorder], or gaining weight [i.e. anorexia nervosa].

#### *Criterion C*

The disturbance does not occur only during the course of a mood disorder or a psychotic disorder.

#### *Criterion D*

At least six of the following 18 symptoms are often present when anxious:

##### Motor Tension

- \* Trembling, twitching, or feeling shaky
- \* Muscle tension, aches, or soreness
- \* Restlessness
- \* Easy fatigability

##### Autonomic Hyperactivity

- \* Shortness of breath or smothering sensation
- \* Palpitations or accelerated heart rate (tachycardia)
- \* Sweating or cold, clammy hands
- \* Dry mouth
- \* Dizziness or light headedness
- \* Nausea, diarrhea or other abdominal distress
- \* Flushes (hot flashes) or chills
- \* Frequent urination
- \* Trouble swallowing or lump in throat

#### Vigilance and scanning

- \* Feeling keyed up or on edge
- \* Exaggerated startle response
- \* Difficulty concentrating or "mind going blank" because of anxiety
- \* Trouble falling or staying asleep
- \* Irritability

#### *Criterion E*

It cannot be established that an organic factor initiated and maintained the disturbance, such as hyperthyroidism or caffeine intoxication.<sup>1</sup>

With these two disorders in mind, once the diagnosis is made a treatment strategy follows. It is now recognized that tricyclic antidepressants and monoamine oxidase inhibitors are excellent anxiolytic medications. With regards to tricyclic antidepressants, a low dose such as 10 mg of amitriptyline (Elavil), nortriptyline (Pamelor), or imipramine (Tofranil) has been used successfully as reasonable first line treatment of anxiety disordered patients. With follow-up, tricyclic antidepressants may be titrated up to 200-250 mg at hour of sleep for amitriptyline and imipramine or with nortriptyline the dosage may be adjusted to 75-125 mg by mouth at hour of sleep. Any practitioner should not be satisfied with less than a 75-80% cure rate of the major symptoms of both panic disorder and/or generalized anxiety disorder with the above regimens.<sup>2</sup> If tricyclic antidepressants are contraindicated or the anxiety disorder is refractory to tricyclics, the physician can switch the patient to a monoamine oxidase inhibitors, which have proven efficacy in anxiety disorder patients. Monoamine oxidase inhibitors have been controversial in the past because of the requirements of dietary restrictions and risk of possible liver toxicity. However, in the hands of experienced clinicians and with appropriate patient selection, these compounds have great clinical utility in both anxiety and depressive disorders. A reasonable strategy to treat an anxiety patient would be to start with phenelzine sulfate (Nardil) 15 mg, one p.o. t.i.d. with appropriate titration over time.<sup>2</sup> Both physician and patient need to be aware of the dietary and drug restrictions when using these compounds.

Ideally, both tricyclic antidepressants and monoamine oxidase inhibitors are best prescribed by well trained, general psychiatrists with clinical experience and reasonably adequate knowledge about their use, risk, and benefits.

#### Case Report

Ms. D.P. is a 25 year old white female, health care worker with a master degree, who began experiencing psychiatric symptoms at age 18, when first admitted to college. She was hospitalized and treated by a general psychiatrist with benzodiazepines and was on these compounds for approximately seven years prior to seeking alternative treatment. Her psychiatric diagnosis was Panic Disorder, without Agoraphobia. The patient had been placed on alprazolam

(Xanax), 0.5 mg, p.o. t.i.d. by her psychiatrist, but the patient's craving for this compound brought her daily total intake up to 10 tablets per day; a total daily dose of 5 mg. The patient was constantly in benzodiazepine withdrawal and also was concerned about the euphoria caused by the alprazolam. When I first examined this patient in my outpatient office, she was benzodiazepine dependent. I concurred with the diagnosis of panic disorder without agoraphobia and began to taper the patient's alprazolam by a half a mg per week. At a alprazolam dose of 2.5 mg per day, the patient experienced autonomic withdrawal and sleeplessness and I placed her on clonazepam (Klonopin) as adjunctive withdrawal medication. We continued to taper her alprazolam (Xanax) which required six months of tapering. When she was at 0.5 mg of alprazolam (Xanax) t.i.d., I added tranylcypromine sulfate (Parnate), a high potency non-hydrazine monoamine oxidase inhibitor, to her regimen. Clonazepam was withdrawn and the alprazolam was tapered over the next month to 0.0 mg and the patient responded quite well. At 20 mg a day of tranylcypromine sulfate, the patient developed orthostatic hypotension and had to be placed back on 10 mg a day. She was very compliant with dietary restrictions and with outpatient follow-up. She did not suffer from alcoholism or drug dependency, though there was a family history of alcoholism in a distant male relative. The patient continued to have craving for alprazolam up to one

year after complete discontinuation of that compound. Her anxious psychopathology has resolved and she ultimately gained full-time employment, was married and did quite well, and her desire to take alprazolam subsided.

This clinical vignette gives credence to the fact that high potency benzodiazepines are not always efficacious and/or indicated in anxious patients. Benzodiazepine compounds have great clinical utility in their own right but there are alternative anxiety disorder treatments that should be looked at possibly first before instituting a potentially drug dependency prone compound.

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# Efficacy of Dextran Therapy in Coronary Angioplasty

Mark Howard Bowles, M.D., F.A.C.A.\*

Anatomic and physiologic consequences of PTCA have been well described.<sup>1</sup> Radionuclide imaging has been used to demonstrate platelet deposition at PTCA sites.<sup>2</sup> This platelet adhesion may further foster thrombosis in areas of denuded endothelium. Furthermore, angioplasty causes derangement of prostacyclin elaboration. As a result, spasm may contribute to the phenomenon of acute occlusion.<sup>3</sup> Heparin anticoagulation has not been shown to attenuate platelet accumulation.<sup>4</sup>

While one study showed ASA prevented platelet adhesion in rabbits undergoing deendothelialization,<sup>5</sup> ASA, NSAIDs, and dipyridamole were of no benefit in another investigation.<sup>6</sup> Additionally, sophisticated tests in platelet function<sup>7</sup> are not readily available in the clinical setting.

Low molecular weight dextran has also been touted for its ability to inhibit platelet adhesion and aggregation.<sup>8,9</sup> However, such favorable effects were not confirmed by more recent animal and clinical studies.<sup>10,11</sup> Despite such data, dextran continues to be used in a number of labs in the country as an adjunctive measure to coronary angioplasty. The purpose of this study was to assess whether dextran could reduce the incidence of acute coronary closure post PTCA; and to determine if platelet modulation could favorably affect fibrocellular proliferation, restenosis and late events.

## Methods

In a two-month period, 192 patients undergoing elective PTCA were randomized to receive 500 ml of 10% dextran or 500 ml of 0.9% saline to be administered immediately before and during the procedure. Pretreatment included dipyridamole 75 mg t.i.d. and aspirin 975 mg per day in the 48 hours prior to attempted angioplasty. Immediate pretreatment included verapamil 10 mg intravenously, heparin 5,000 units intravenously, and nitroglycerin paste, two inches topically. PTCA was performed with standard techniques using ACS catheter systems. Successful angioplasty meant 30% im-

provement in luminal diameter and <50% residual stenosis.

Definitions utilized in the study were:

1. Acute Occlusion: Total or high-grade obstruction of the coronary artery occurring immediately after PTCA in the laboratory setting.
2. Hospital Restenosis: Loss of  $\geq 50\%$  of the gain effected by PTCA; repeat coronary study prompted by:
  - (a) recurrent chest pain with ST change, or
  - (b) abnormal treadmill exercise test.
3. Late Restenosis: Loss of 50% of gain, documented by angiography or inferred by re-PTCA, CABG, MI and death.

Table I. Study Group Characteristics

Variable	Dextran	Control
	N = 87	N = 105
Age $\geq 70$	11 (12.6%)	19 (18.0)
Mean Age	59.5	59.3
Male Sex	78%	80%
LMCAD	02 (2.2%)	03 (2.8%)
LVEF < 30%	10 (11.4%)	16 (15.2%)
SUCCESS*	205/208 (98.5%)	271/282 (96%)

Patient follow-up information was derived from office charts of attending cardiologists, office data of referring physicians and telephonic interview with patients and family members. Data were analyzed with Chi-square analysis. P values less than 0.05 were considered unlikely due to chance association.

\* Dr. Bowles is affiliated with the Wichita Institute for Clinical Research in Wichita, Kansas.



**Table 2. Acute Events**

	Dextran # (%)	No Dextran # (%)	P Value
<b>ACUTE OCCL</b>			
Lab Reoccl	2 (2.3)	5 (4.8)	NS
<b>HOSP RS</b>			
CP,ST CHG	1 (1.1)	1 (1.0)	NS
+ TMET	0 (0.0)	2 (1.9)	NS
<b>Total Events</b>	<b>3 (3.4)</b>	<b>8 (7.6)</b>	<b>NS</b>

## Results

Eighty-seven patients received dextran and 105 were in the control group. The two groups were comparable for mean age, male sex, age greater than 70 years, severe left ventricular dysfunction, and the incidence of left main coronary artery disease (Table I). Coronary balloon angioplasty was successful in 99.5% of dextran and 96% of control patients. Total acute events, including laboratory occlusion and hospital restenosis, occurred in 11 of 192 patients for an incidence of 5.7%. The incidence of these two events between the two groups was not statistically significant (Table II). Acute coronary occlusion during PTCA occurred in two dextran patients (2.3%) versus five (4.8%) patients not receiving dextran. This 50% reduction, however, was not statistically significant. Coronary dissection was complicated by hospital restenosis in one dextran and one control patient, and required repeat dilatation. One late hospital death occurred in the dextran group but was unrelated to acute occlusion. There were no MIs or urgent CABG procedures in either group.

**Table 3. Incidence of Late Events**

	Dextran # (%)	No Dextran # (%)	P Value
RE-PTCA	24 (29)	22 (23)	0.12
CABG	8 (10)	12 (12)	0.17
MI	4 (5)	2 (2)	0.19
DEATH	2 (2)	3 (3)	.038
<b>TOTAL</b>	<b>38/83 (46)</b>	<b>39/97 (40)</b>	<b>NS</b>

One hundred and eighty-one subjects were then eligible for long-term follow-up and 97% were contacted at approximately 14 months post angioplasty. Specifically, 93% of the dextran and 100% of the control groups were available and evaluable.

A total of 38 late events occurred in dextran patients while 39 events occurred in control patients in the follow-up phase. The total number and specific events did not significantly differ between the two group (Table III).

## Conclusion

These data do not support a protective role for dextran in elective PTCA. The premises that dextran would affect platelet adhesion, aggregation, release reaction, and intimal hyperplasia were not supported by the course of the dextran cohort.

Additionally, dextran has potential for significant adverse effects such as volume overload and life-threatening anaphylactoid reactions.<sup>12,13</sup> As such, patients must be observed carefully with institution of this therapy.

In light of these known liabilities and unproved efficacy, dextran cannot be recommended as an ancillary measure in elective coronary angioplasty.

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# Where Have All the Patients Gone?

If your patient load has been decreasing, you are not alone. A recent survey indicates that less than half of the physicians in the nation have an increasing patient load. With a physician surplus and increasing competition from a variety of sources, do physicians have any options to counteract a present or future loss of patients? The American Medical Association believes that effective marketing could cure some ills.

According to the AMA's Department of Practice Management, many physicians are scared by the very term "marketing." To them, marketing connotes advertising, hardsell tactics, deceptive gimmicks and tasteless huckstering. Many physicians do not want to "resort" to marketing their services because they believe their services should sell themselves. Dwindling patient loads indicate that this is not true anymore. The working definition of marketing is that of an ongoing process of finding out what your patients need and what your patients perceive their needs to be and then matching your services to those needs.

Physicians must remember that they are in business - the business of providing service to patients. Therefore, patient satisfaction must be a primary goal of any practice. A general rule of thumb is that a satisfied patient will relay his feelings to five other people; a dissatisfied patient will tell 10 others. A successful practice usually depends on three important "A's" of medicine: ability, availability and amiability. Today, a fourth "A" can be added: affordability.

A good marketing program begins with a physician closely inspecting his or her practice. Based upon these observations, the physician can develop a marketing program that should include the following: positioning strategies, pricing strategies, strategies to increase availability, strategies to expand services, promotional strategies and strategies to increase patient satisfaction. Detailed examples of each will be cited later in this article.

Once you analyze your current situation you can best determine where you want the practice to go and the best way

to achieve the results. Things to consider include the current makeup of your patient load (Are these the types of patients you want?), the practice's geographical location (Is the area growing? Is it mostly residential or commercial?) and how

did the patients come to you in the first place? Honest answers and evaluations can help a physician create a realistic and effective marketing program.

Physicians need to honestly answer the questions of what they want most from their practices before embarking upon a marketing program. For some it will be being able to spend more time with their families, and for others it might be the most effective way of delivering optimum health care. Marketing strategies vary; they depend on the ultimate goals of each practice.

Once a marketing program is implemented it should be considered as an ongoing process. You should be continually

monitoring the various marketing strategies you are employing to determine if they really are doing what you thought they would. Give each strategy a reasonable trial period to produce results, but don't be afraid to modify or phase out unsuccessful ventures. Try to remain sensitive to changes in the community's perceived health care needs, and to developments in your area that might have a significant impact on your practice.

## Availability to Patients

If your goal is to increase your availability to patients, remember that convenience is becoming an increasingly significant factor in the choices made by patients. If you are not available to patients when they need you, they often will look elsewhere. The following could improve your availability:

- \* Institute non-traditional office hours such as evening hours, early morning hours and weekend hours.
- \* Improve your availability by telephone. Arrange with a phone company service representative to have a free

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## Nearly 100 Suggestions for Getting and Keeping Your Patients

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peak load or busy signal study done in order to estimate your equipment and staffing needs. Patients do not like to get busy signals when calling a doctor's office.

- \* Establish definite callback periods in your office.
- \* Install a toll-free 800 number if you have many patients outside your immediate area.
- \* Establish "call in" hours during which patients can speak immediately to a physician or nurse.
- \* Make house calls. Nearly one-third of the physicians in the nation now make house calls. Let selected patients know of your availability for home visits.
- \* Redesign your facilities to provide for easier access to wheelchair patients, infirm patients, etc.
- \* Locate your office in or near a shopping center. You may not only be more accessible to your regular patients, but available to serve the needs of shopping center employees as well.
- \* Use a patient beeper system. If you are within easy walking distance of a shopping area, allow patients to shop in the event of unavoidable delay and recall them to your office through a beeper system.
- \* Use referral services.
- \* Open a satellite office in an underserved area. Be sure, however, to research such a project carefully before proceeding to be sure that it will be cost effective. In smaller practices, once increased overhead costs and travel times are taken into consideration, satellite offices often prove not to be cost effective.
- \* Reschedule follow-up visits. Don't just tell a patient to call for an appointment in six months and assume he will.
- \* Send reminders for annual health care visits. A reminder network can be set up and might be coordinated with the patient's birthday so that he receives from you a combination birthday card/reminder notice.
- \* Provide child care services. Incorporate babysitting or day care services into your practice, or locate in an area where such services are readily available.
- \* Provide full-service assistance. Larger multi-specialty groups might employ a "referral coordinator" to help patients choose the appropriate specialist, as well as handling appointment scheduling, collecting pre-visit information and answering financial and insurance questions.

## Patient Relations

If one of your goals is to have enthusiastic patients, there are many services that can get you results. Clinical competence alone will not create satisfied patients who are enthusiastic about recommending your services to others. Patients want to be cared for by a warm and caring human being. Patients want to know you care about them as well as care for them. The following are things that can be done to enhance a patient's satisfaction:

- \* Send a welcome letter to a patient after the initial

appointment has been made. Thank the patient and enclose a patient information handbook.

- \* Handle phone calls courteously - the staff should never use the word "busy" when a patient asks to speak to the physician.
- \* Acknowledge arriving patients immediately upon arrival.
- \* Always address a patient by name as far as possible. Be very sensitive to patients' feelings in deciding to use formal or informal terms of address.
- \* Explain all lengthy delays, and make sure that patients are given the opportunity to reschedule if they so desire.
- \* Provide interesting, up-to-date reading material for your patients. In some instances, provide a television set (with the volume controlled). Many patients might appreciate a copy of the daily paper. Parents often appreciate comic books or children's literature for their youngsters.
- \* Provide refreshments - coffee, juice, etc.
- \* Provide educational materials; they usually result in patients who are willing to assume responsibility in assisting you in the healing process. Many forms are available - write your own educational materials, produce your own video or audio cassettes, establish an office library, etc.
- \* Provide a telephone for your patients' use either in your reception area or an adjoining hallway.
- \* Ask about the patient's family. Some physicians jot down personal notes about each patient and keep them in the patient's chart. A few physicians even have photographs taken of each patient and attach them to charts to refresh the physician's memory.
- \* Spend adequate time with each patient. Surveys indicate that patient satisfaction is directly correlated with the amount of time the physician spends with the patient.
- \* Answer patient questions. The basic questions that must be answered are: "What is wrong with me?" "What caused it?" "What are you and I going to do about it?" "How long is it going to take?" "How much is it going to cost?" "What effect will it have on activities?"
- \* Maintain eye contact with your patients while you are talking with them.
- \* Never interrupt or contradict a patient's objections. Instead, listen, restate, paraphrase, and explain.
- \* Explain the necessity of all lab tests and x-ray examinations which you order and the billing procedures for such examinations.
- \* Inform patients about what happens after they leave. Let them know what you will be doing for them before their next visit, and that you will follow the progress of their case.
- \* Walk patients to the door, or in some other way bring your encounter with the patient to a cordial conclusion. After a patient has visited your office, there are many things that can be done to insure good will. This list includes the following:



- \* Call patients a few days after their visits to see how they are doing, when appropriate. Most patients will greatly appreciate your concern.
- \* Call with good lab results. Patients appreciate knowing all is well.
- \* Send holiday cards, birthday cards.
- \* Send flowers to a new mother, or treat the new parents to dinner.
- \* Stamp "thank you" on all patients' cancelled checks.

## Expansion of Services

If your practice's goal is to expand services to meet changing patient needs, you must identify a group of patients with specific needs or desires, and then design new services or expand existing services. Some suggestions follow:

- \* Expand the scope of your practice beyond the traditional parameters of your specialty. A pediatrician, for example, might expand his practice to include the primary care needs of adolescents and young adults.
- \* Buy other practices. Consider buying the practices of physicians in your area who are moving or retiring.
- \* Enter into contracts. Take opportunities to enter into appropriate service contracts to deliver care.
- \* Institute a full-time emergency care program. This will necessitate that at least one health care professional be available around the clock.
- \* Open a primary care satellite or a convenience clinic. This is most appropriate for multi-specialty or hospital-based physician groups.
- \* Do in-office outpatient surgery.
- \* Expand the facilities, equipment and staff within your office to enable you to do recognized in-office surgical procedures.
- \* Establish a comprehensive fitness or exercise program to complement your other services.

## Promotion

Patients can't choose you as their physician if they don't know you exist. If your goal is to increase your visibility and promote your services, you might consider the following ideas:

- \* Become active in your community - join your local medical groups, volunteer to serve on medical society committees, join worthwhile community groups.
- \* Get to know respected community members, especially pharmacists and members of the clergy. They get many requests for the names of good physicians.
- \* Do volunteer work. Volunteer for emergency room rotation, or for work in nursing homes, hospices, etc.
- \* Use your interest to your advantage. Become affiliated with groups which share your hobbies and enthusiasms, and whose members may have a particular reason for seeking medical care from a fellow member.

- \* Become involved in your local schools - participate in career nights, sponsor scholarships, serve as a team physician, buy space in the school yearbook, etc.
- \* Volunteer to speak before community groups, school groups, neighborhood associations, etc.
- \* Give free health screenings at community centers.
- \* Sponsor or participate in a health fair.
- \* Prepare a patient information handbook and distribute it effectively.
- \* Develop a patient newsletter. It will be most effective if it is written directly by you and your staff and directed specifically to topics and questions most often encountered in your practice. Newsletter items might include health tips, a question and answer column, and explanation of office procedures, book reviews, etc.
- \* Develop a logo for your practice and put it on everything - office stationery, invoices, business cards, handbooks, doors, etc.
- \* Dispense small health-related items which patients can take with them as a gift from your office.
- \* List yourself in the Yellow Pages.
- \* Carry business cards with your practice's name, address and phone number. Such cards should always be available to anyone you encounter. Also, give cards to nurses and assistants, who occasionally are asked who they work for.
- \* Write letters to the editor of the local newspaper on topical issues on which you are competent to speak.

## Pricing

Patient surveys consistently reflect patient dissatisfaction with "high" fees. The following are some options you might want to use to meet your patients' need to understand and deal with your fees.

- \* Price yourself effectively. Choose a price strategy that is not only fiscally sound but also sensitive to the financial needs of your patients.
- \* Examine the local pricing environment, especially as it is influenced by government, business and third party payor policies.
- \* Develop credit policies; put them in writing and make sure your patients know about the policies.
- \* Always be willing to discuss and explain your fees.
- \* A written fee schedule should be available to patients upon request.
- \* Request payment at time of service for moderate medical charges, and educate patient as to how this will cut costs for them.
- \* Offer discounts to patients for payment at the time of service.
- \* Donate services to unemployed or indigent patients, either as an individual or as part of a program sponsored by the local medical community.
- \* Accept credit cards.

- \* Offer inducements of free or discounted services to introduce patients to your practice.
- \* Help patients understand their insurance policies - what will and won't be covered - before service is rendered.

## Referrals

One way to insure a busy and successful practice is to get referrals from other physicians and patients. Certain marketing tips can help you in your practice. Specialists who rely on other physicians for the bulk of their patients must market themselves to these other physicians in the same way that primary care physicians must market themselves directly to patients.

The following are suggestions on how to be a good referring physician:

- \* Contact a consultant in a personal manner and with respect. Writing an order and letting the nurse make the call is not sufficient.
- \* When initiating a call to a consultant, be on the line. Do not keep the other physician waiting; this is sure to cause resentment.
- \* Be sure you make the distinction between a consultation and a referral. If you wish the patient back, make sure the consulting physician knows that you are referring the problem and not the patient.
- \* Don't wait until the last minute to refer patients. Give the consultant time to study the patient's history.
- \* Tell the patient why he is being referred. Make sure the patient acquiesces to your choice of consultant.
- \* Don't dump troublesome patients on consultants just to get rid of them.

- \* Some consultants may appreciate a report on the final disposition of a case in which they played a part. If so, provide this report.
- \* Keep track of all referred patients.

The following are ideas on how to increase referrals from your colleagues:

- \* Develop a written information sheet for the physicians who refer to you. Detail the goals, policies and procedures by which you handle referral patients, and list the various services you offer to referring physicians.
- \* Try to be as accommodating as possible in meeting the needs of both the referring physician and the patient by seeing the patient promptly.
- \* Install a private telephone line in your office that is connected to a recording device. Inform referring physician of this private number and invite them to dictate consultation requests or patient information at their convenience.
- \* Do your best to return patients to the referring physician. Do not steal patients. If a referred patient chooses to remain under your care, discuss the situation with the referring physicians as honestly and tactfully as possible.
- \* Always report back promptly to a referring physician.
- \* Do not belittle the treatment the patient has received from the referring physician. Any disagreements about treatments should be resolved with the referring physicians.
- \* Do not overcharge for your services. Complaints and resentments about excessive fees will be directed not only at you, but at the referring physician as well.

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NETWORKING

ACCEPT ASSIGNMEN

CROSSOVER CLAIM

EDS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER

PLACE OF SERVICE CODE

HICFA

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING

LEDGER CARDS

WRITE-OFF

PARTICIPATING PHYSICIAN

ROOM

INSURANCE CARDS

GROUP POLICY NUMBER

CHARGE SLIPS

MEDICARE

DISABILITY

PATIENT STATEMENTS

RELATIONSHIP TO THE INSURED

PAYMENT

APPROVED

AMOUNT

TYPEWRITER

APPOINTMENT BOOK

EXAMINATION ROOM

TICKLER FILES

CODING REQUIREMENTS

SELF PAYS

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# Changes in Society Have Affected the Relationship Between Physicians and Their Patients

Robert J. Miller\*

Within this century, as the life-span of the average American increased, the sacrosanct doctor-patient relationship began to change. It has continued to change until patients and their physicians must search for some new means of communicating, of rebuilding that special relationship.

In 1891, patients had very few choices in their medical care - if they received any at all. There were very few specialists and people who were lucky enough to have a family doctor, were often delivered, treated through childhood, into adulthood, and perhaps even declared dead by the same physician.

Patient care was provided on a personal basis. Lack of technology made the physician an integral part of the patient's life and community as well as of his/her health care. Sometimes the only care the physician could offer was his emotional support while the patient either rallied or failed. The best physicians were those whose emotional support and concern empowered the patient to heal. The brilliant Canadian physician, Sir William Osler, firmly believed that many patients survived because their physicians told them they would.

## Patients Have Changed

Patients today still fear the unknown, particularly pain or the possibility of crippling accidents. Most people who are sick or injured, are not in the best emotional frame of mind.

But patients have changed. Some of the changes are positive for both physician and patient. But other changes can bring about calamity for both.

Americans have greater access to health care information than ever before. And they are paying attention to it. This desire for information about nutrition and health issues may provide physicians with patients who are more eager to participate in their health care, who ask more questions, and who are more likely to follow their physicians' medical directives. On the other hand, nearly every doctor has a story to tell about the patient who, having read an article in a magazine, arrives at an appointment armed with a complete list of symptoms - and a bizarre diagnosis!

The American interest in consumerism has also begun to influence American medicine and the wise physician does well to answer patients questions, both legitimate and trivial, both logical and emotional. Whatever the patient's concerns may be, they will affect the outcome, both for doctor and patient alike.

Improvements in medicine have given rise to the "take a pill" school of consumer health demands. Every doctor has seen patients who believe that they have little responsibility for taking care of their own health. They smoke, drink to excess, eat foods that are not healthful, lead sedentary lives - and when they become ill, they assume that is the physician's responsibility to "fix" them. Americans expect instant relief from headache, indigestion, aching muscles...and the list goes on.

## Technology Has Changed

There is a school of thought that proposes that medicine is increasingly practiced as a science rather than as an art. Inventions, new techniques, medications, testing procedures, etc. have come between the physician and her patient. New technology must not be allowed to remove humanism from medicine, turning the physician into a technician.

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\* Mr. Miller is the vice president of Consumer Affairs and Risk Management for the Medical Protective Company of Fort Wayne, Indiana.



Medical schools re-examine curricula seeking to examine the possibilities inherent in staying healthy. Science alone is not sufficient doctors discover. Communication skills are the new "buzzwords" as professional liability insurers share with their insureds the information that more suits result from acts of unkindness or disinterest than from actual negligence.

Technology enhancements must not be allowed to put a distance between physician and patient. It may be that increased efforts of communication may be necessary from both parties. Technology is a tool; so is communication. Neither may preclude the other.

A recent survey, conducted by the Texas Medical Association, questioned the patients and their families who were claimants in 263 suits against physicians. Over half of those surveyed said that their doctor's attitude had been so poor, they'd wanted to sue - even before the alleged malpractice incident occurred.

Norman Cousins, American essayist and editor, wrote in his "Anatomy of an Illness" that medicine must return to the close relationship between patient and physician. The ability to "do" more by way of mechanistic processes must not hinder the physician's ability to "be" more to his/her patients. Many Americans believe that physicians no longer care about them.

## **Society Has Changed**

The majority of physicians are still men; the majority of patients are still women - but they are no longer the passive, unquestioning shy violets of the past. They are better-educated about health issues than their male counterparts, and they have more questions about their illnesses and treatments. They are also more likely to comply with their doctor's instructions than are men.

Within the last few months, we have seen the medical community called to task for the disproportionately small number of women who are included in testing of new drugs or surgical procedures. We have read charges that women are less likely to be offered some forms of diagnostic testing, testing that is standard for most male patients. We have seen a highly-respected female physician resign from an important position with a famous medical center, charging that continued sexism and harassment over the years had simply worn down her commitment to the organization.

As society deals with gender politics issues, so must the medical community.

Increasingly, Americans are becoming aware of the cost

of health care. As medical and dental services become more and more expensive, growing numbers of Americans find themselves without the means to pay for these services. The United States has the largest number of uninsured citizens of any major country.

It is likely, contend some health care specialists, that, faced with insurmountable medical bills, some individuals may feel pressured to sue. Studies have been unable to prove this thesis, but one thing is certain. Medicine is becoming more adept at identifying the scientific differences between actual malpractice and unpreventable complications. While this knowledge bodes well for the ultimate long-range improvement of care, it increases the chances that an individual doctor may be sued, successfully.

## **The Plaintiff's Bar**

"Are you a person who's been injured?" booms the voice of the plaintiff attorney, soliciting prospective clients through the increasing use of television commercials. "Who's going to pay for your injury?" inquires the unctuous voice of the television audience. Implicit in this enthymeme is the premise that

SOMEBODY MUST PAY. It is currently a given, within the American tort system, that blame must be placed whenever a child is born with a birth defect, a surgery is not completely successful, or some poor soul dies. While it would be foolish to deny that there are acts of negligence that do indeed result in injury to patients, it is also foolish to claim that every injury results from negligence.

In the recent Harrison Fort movie, "Regarding Henry," the Mr. Hyde character of Henry (before his rejuvenation as a loving human being) is such an ogre that he is a defense attorney for a hospital!

## **The Media's Contribution**

With its insatiable desire to provide viewers/readers with up-to-the-minute news, the media frequently seek to cover complicated issues in abbreviated "between commercial" segments. Looking for sound bites rather than substantial content matter, television and newspapers frequently aggravate animosities by dealing with superficial elements of such issues as tort reform, the cost of health care, the intricacies of liability insurance, and legislation aimed at relieving the cost and stress suffered by most of the parties involved.

While American discontent with health care services cannot be blamed on the media, they can be called to task for exacerbation of this rift.

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# **Society, Technology, the Media, and Plaintiffs' Bar Have Contributed to the Change in Doctor-Patient Relationship**

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## Mending the Problem

Making use of statistical information provided by their insurer, many medical and dental education programs are looking at their curricula with plans to emphasize greater interpersonal skills as an essential tool for future graduates.

Surveys show that most Americans, while displeased with a perceived lack of interest on the part of the profession, are generally pleased with their own family practitioners. They are not content with an impersonal, distant relationship with providers of health care, including physicians, dentists, hospitals, nurses, etc. The increased communication can foster greater trust - on both sides. Physicians have also suffered from an understandable loss of trust. Just ask any doctor who has been sued. It becomes very difficult to see patients as anything other than the source of the next lawsuit.

Insurance companies seek to identify physicians who need help with the communication aspects of their practices. Educational programs are available to assist doctors and their staffs to communicate clearly and compassionately with patients - while at the same time maintaining suit-proof records. Loss prevention prevents the best way to deal with malpractice suits - by avoiding them.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

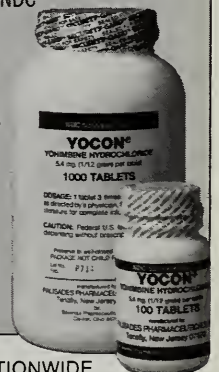
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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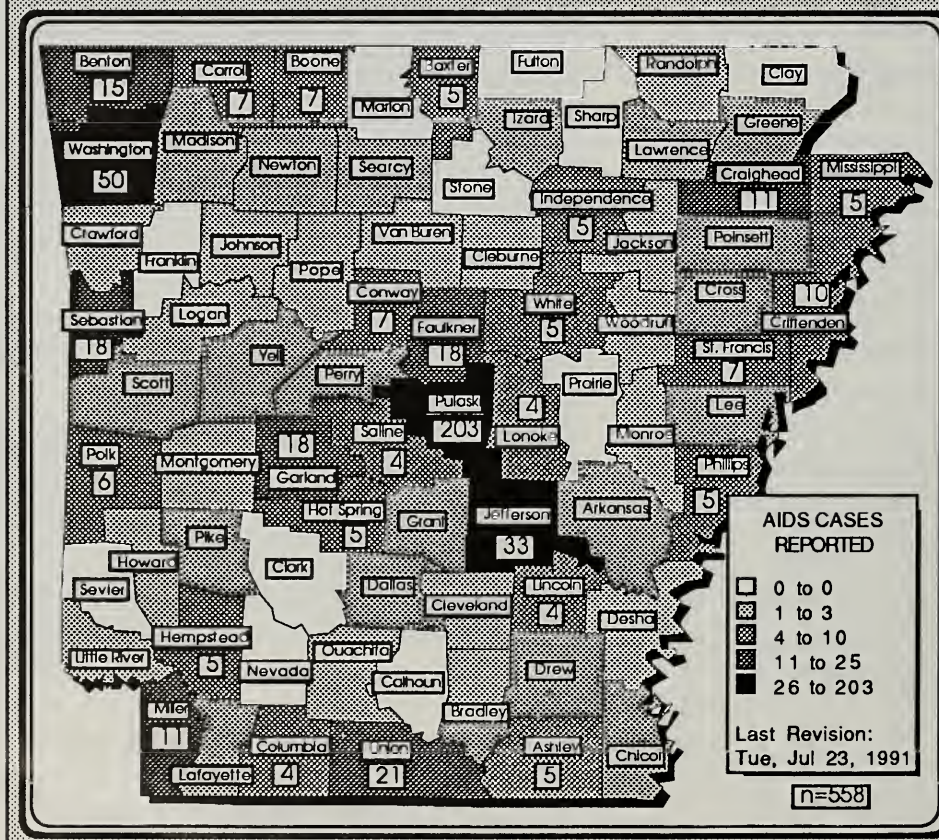
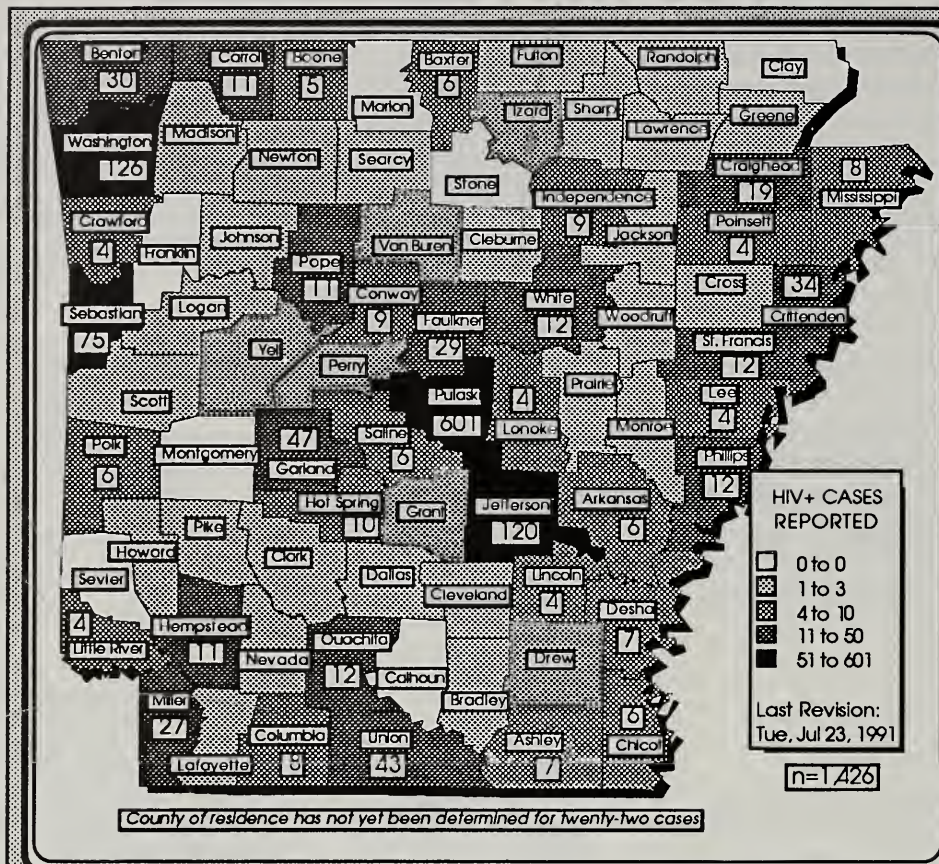
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# Arkansas HIV/AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statutes 20-15-904, 15-14-123, 16-82-101 and Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

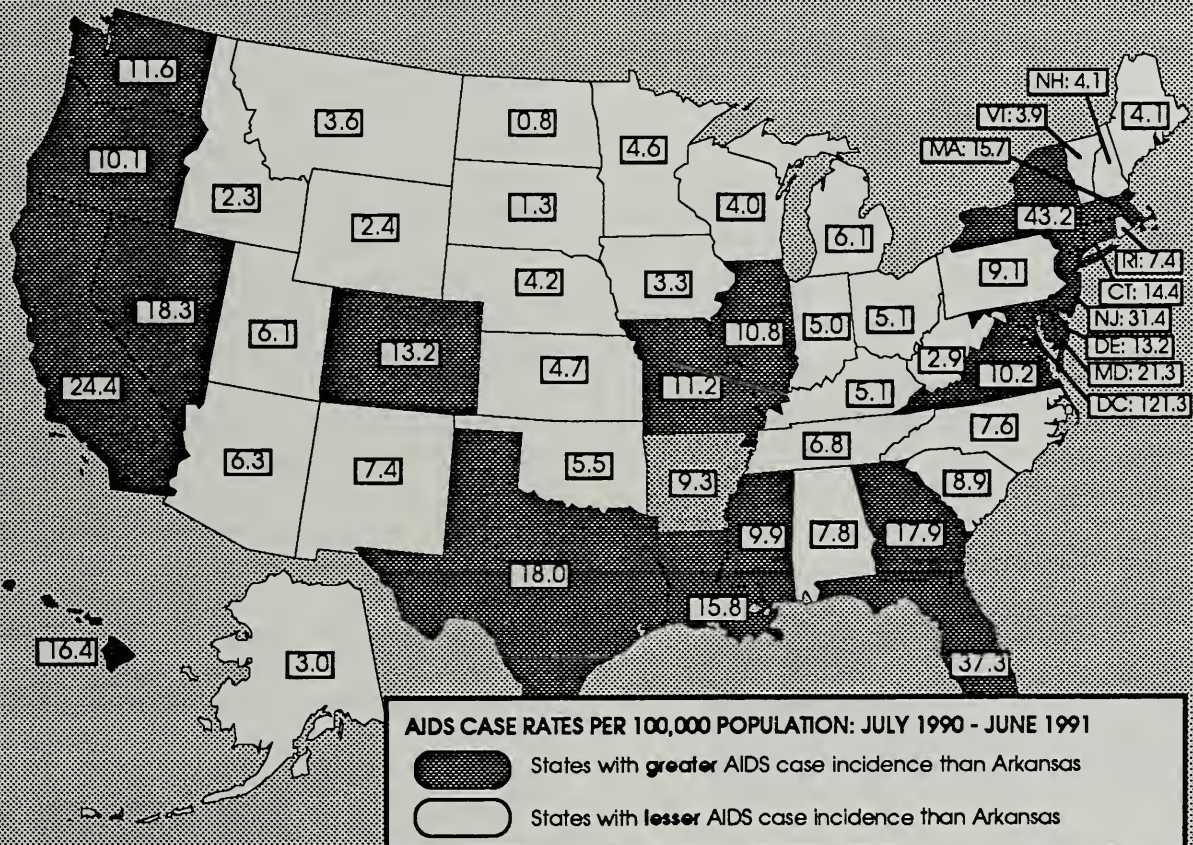
Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# Arkansas AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: JUNE '90 - JUN '91	238	Reported: JUNE '90 - JUN '91	43,052
Rates per 100,000 population: JUN '90 - JUN '91	9.3	Rates per 100,000 population: JUN '90 - JUN '91	16.9
Cumulative Reports: 1983 - JULY '91	558	Cumulative Reports: 1980 - JULY '91	182,834
Adult	544	Adult	179,694
Pediatric	14	Pediatric	3,140
Deaths: 1983 - JULY '91	315	Deaths: 1980 - JULY '91	115,984
Adult	309	Adult	114,338
Pediatric	6	Pediatric	1,646
Mortality Rate	56.5%	Mortality Rate	63.4%



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	62.2%	Gay or Bisexual Men	57.8%
Heterosexual IV Drug Users	11.5%	Heterosexual IV Drug Users	21.8%
Gay or Bisexual Men who used IV Drugs	9.5%	Gay or Bisexual Men who used IV Drugs	6.5%
Heterosexual contact with person at risk	5.6%	Heterosexual contact with person at risk	5.5%
Transfusion with blood products	4.3%	Transfusion with blood products	2.3%
Perinatal	2.0%	Perinatal	1.4%
Hemophilia	2.0%	Hemophilia	0.9%
Risk unknown at this time	3.4%	Risk unknown at this time	3.7%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# New Members

---

## BAXTER COUNTY

**Adkins, Kevin J.**, Family Practice, Mountain Home. Born, August 23, 1955, Blytheville. Medical education, UAMS, Little Rock, 1988. Internship/residency, AHEC-Jonesboro, 1991.

## BENTON COUNTY

**Rodgers, H. Lynn**, Orthopaedic Surgeon, Rogers. Born, May 24, 1954, San Antonio, TX. Medical education, Louisiana State University Medical Center, Baton Rouge, LA, 1982. Internship, Earl K. Long Memorial Hospital, 1983. Residency, John Peter Smith Hospital, 1988. Practice experience, 3 years. Board eligible.

## CRAWFORD COUNTY

**Floyd, Rebecca R.**, Family Medicine, Van Buren. Born, August 28, 1952, Lawrence, KS. Medical education, UAMS, 1987. Internship/residency UAMS, 1990.

## LAFAYETTE COUNTY

**Harbin, Bradley**, Emergency Medicine, Stamps. Born, May 21, 1950, Holland, MI. Medical education, University of Oklahoma College of Medicine, Tulsa, 1979. Internship, University of Oklahoma College of Medicine, Tulsa, 1980. Practice experience, 11 years.

## POPE COUNTY

**Gately, Stanley E.**, Anesthesiology, Russellville. Born, September 10, 1958, Ft. Smith. Medical education, UAMS, 1984. Residency, UAMS, 1987. Practice experience, 4 years.

**Soto-Figueroa, Sergio F.**, Adult Cardiology, Russellville. Born, October 29, 1949, Punta Arenas, Chile. Medical education, Universidad de Chile, Valparaiso, 1974. Internship, Charity Hospital of Louisiana, New Orleans, 1980. Residency, Texas Heart Institute, Houston, 1984. Practice experience, 6 years. Board certified.

## PULASKI COUNTY

**Barton, Gary M.**, Gastroenterology, North Little Rock. Born, June 20, 1960, Madison, WI. Medical education, UAMS, 1985. Internship/residency, UAMS, 1989. Fellowship, University of Texas, San Antonio, 1991. Board certified.

**Baskin, Barry D.**, Physical Medicine and Rehabilitation, Little Rock. Born, June 25, 1954, Malvern. Medical education, UAMS, 1987. Internship/residency, UAMS, 1991. Pending certification.

**Doncer, Richard P.**, Family Practice, North Little Rock. Born, December 20, 1951, Chicago, IL. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991.

**Hagans II, James E.**, Oncology, Little Rock. Born, November 3, 1955, San Diego, CA. Medical education, UAMS, 1985. Internship/residency, Baylor University Medical Center, Dallas, TX, 1991. Board eligible.

**Houston, Samuel T.**, Urology, North Little Rock. Born, March 12, 1954, Woodland, CA. Internship, Huntington Memorial Hospital, Pasadena, CA, 1984. Residencies, University of Cincinnati Medical Center, Ohio, 1986; Montefiore/Albert Einstein Medical Center, New York, NY, 1988; UCLA, Los Angeles, CA, 1989; UAMS, 1991. Board eligible.

**Kramer, Thomas A.**, Psychiatry, Little Rock. Born, June 3, 1957, Orange, NJ. Medical education, New York University School of Medicine, New York, NY, 1983. Internship/residency, NY Hospital Cornell University, 1987. Practice experience, 3 years. Board certified.

**Martinez, Luis H.**, Internal Medicine/Critical Care, Little Rock. Born, August 8, 1959, Sinton, TX. Medical education, University of Texas SW Medical Center, Dallas, 1985. Internship/residency, St. Louis University Hospitals, MO, 1988. Practice experience, 3 years. Board certified.

**Medlock, Rickey D.**, Ophthalmology, Little Rock. Born, June 27, 1953, Cave City. Medical education, UAMS, 1983. Internship, University of Hawaii, Honolulu, 1984. Residency, UAMS, 1988. Practice experience, 3 years. Board eligible.

**Pierce, William B.**, Radiology, Little Rock. Born, May 15, 1959, Pasadena, TX. Medical education, University of Texas SW, Dallas, 1985. Internship/residency/fellowship, Baylor University Medical Center, Dallas, 1991. Board certified.

**Sheppard, Joseph E.**, Hand Surgery, Little Rock. Born, August 25, 1952, Burns, OR. Medical education, University of Florida, 1979. Internship/residency, fellowship, University of Florida, 1985. Practice experience, 6 years. Board certified.

**Shuffield, James E.**, Internal Medicine, Little Rock. Born, September 2, 1957. Medical education, UAMS, 1985. Internship/residency, Barnes Hospital, St. Louis, MO, 1991. Board certified.



## SEBASTIAN COUNTY

**Craft, Charles W.**, Osteopathic Medicine, Greenwood. Born, October 18, 1951, Riverdale, MD. Medical education, Kirksville College of Osteopathic Medicine, MO, 1978. Internship/residency, David Grant USAF Medical Center, Travis AFB, CA, 1981. Practice experience, 10 years. Board certified.

**Waack, Timothy C.**, Internal Medicine/Cardiology, Fort Smith. Born, December 3, 1950, Clinton, IA. Medical education, University of Oklahoma, Oklahoma City, 1976. Internship/residency, University of Oklahoma, Oklahoma City, 1979. Board certified.

## RESIDENTS

**Alexander, Arnold G.**, Internal Medicine. Born, September 4, 1958, Little Rock. Medical education, UAMS, 1991. Internship/residency, UAMS.

**Baker, Kevin G.**, Family Practice. Born, August 31, 1966, Little Rock. Medical education, College of Osteopathic Medicine, Oklahoma State University, 1990. Internship, Tulsa Regional Medical Center. Residency, AHEC-NW.

**Carney, Stephen E.**, Family Practice. Born, June 30, 1960, Memphis, TN. Medical education, UAMS, 1988. Internship, AHEC-NE. Residency, AHEC-NE & AHEC-Pine Bluff.

**Cole, Evan D.** Born, October 15, 1963, Peoria, IL. Medical education, College of Osteopathic Medicine, Oklahoma State University, 1991. Internship, AHEC-Pine Bluff.

**Collins, Kimberly J.** Born, December 16, 1964, Searcy. Medical education, UAMS, 1991. Internship, AHEC-NW.

**Cooper II, James K.** Medical education, West Virginia School of Medicine, Lewisburg, WV, 1991.

**DeYoung, Bruce.** Born, July 26, 1965. Medical education, UAMS, 1991. Residency, AHEC-NW.

**Filbeck, Kenneth J.** Born, July 3, 1962, Bangkok, Thailand. Medical education, Southern Illinois University School of Medicine, 1991.

**Haider, Riaz,** Family Practice. Born, October 12, 1958, Lahore, Pakistan. Medical education, American University of the Caribbean, 1989. Internship, AHEC-Pine Bluff.

**Harvey, Bryan M.** Born, October 3, 1962, Sherman, TX. Medical education, University of Texas Health Sciences Center, San Antonio, 1991. Internship, Arkansas Children's Hospital, Little Rock.

**Haws, Karl W.** Born, December 30, 1961, Miami, OK. Medical education, College of Osteopathic Medicine of Oklahoma State University, 1990. Internship, Still Regional Medical Center, Jefferson City, MO.

**Jain, Parker K.** Born, September 10, 1960, India. Medical education, West Virginia School of Medicine, 1991. Internship, AHEC-Pine Bluff.

**Jordan, Raymond,** Family Practice. Born, November 4, 1953, Shreveport, LA. Medical education, Texas College of Osteopathic Medicine, 1990. Internship, E.A. Conway Hospital, Monroe, LA.

**Letcher, Charles T.**, Born, October 21, 1952, St. Louis, MO. Medical education Emory University School of Medicine, 1984. Internship, AHEC-Pine Bluff.

**Mitchell, James Keith.** Born, May 18, 1965, Hot Springs. Medical education, UAMS, 1991.

**Qureshi, Waqar A.** Born, December 3, 1956, Pakistan. Medical education, Royal Free Hospital, London, England, 1983. Internship/residency, Highland Hospital, Rochester, NY. Fellowship, UAMS, Little Rock.

**Schauder, Craig S.**, Dermatology. Born, December 21, 1960, Detroit, MI. Medical education, University of Michigan, Ann Arbor, 1987. Internship, University of Alberta, Edmonton, Alberta, Canada. Residency, University of Texas, Houston.

**Tait, Amy S.**, Pediatrics. Born, August 22, 1958, Kansas City, KS. Medical education, University of Kansas School of Medicine, 1986. Internship/residency, Indiana University School of Medicine, 1989.

**Turner, Sammy L.** Medical education, UAMS, 1991. Internship/residency, AHEC-NW.

**White, Edward L.**, Family Practice. Born, August 25, 1963, Corpus Christie, TX. Medical education, UAMS, 1991.

**Yates, Jeffrey K.** Medical education, West Virginia School of Medicine, 1991. Internship, AHEC-Pine Bluff.

## STUDENTS

**Halderman, James R.**

**Wilson, Donald P.**

**Woodard, Eric A.**



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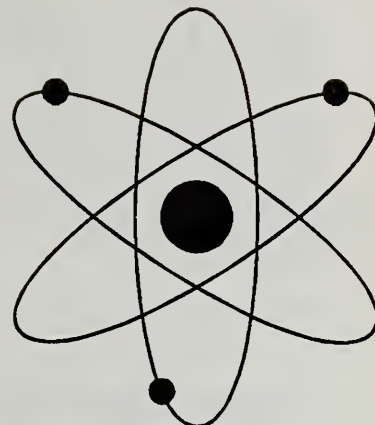
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# Radiological Case of the Month



Rudy L. Van Hemert, M.D.  
Teresita Angtuaco, M.D.  
David L. Harshfield, M.D.  
Steven R. Nokes, M.D.



Figure 1a. Whole body anterior image  $^{99m}\text{Tc}$  labeled leukocyte scan.

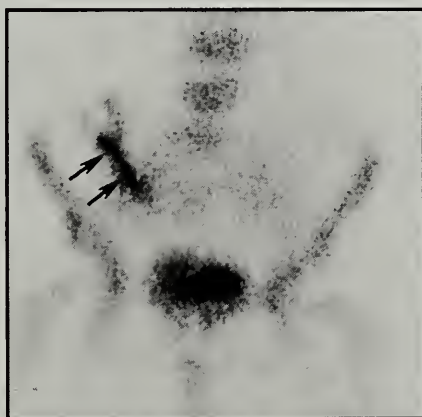


Figure 1b. Anterior spot of abdomen  $^{99m}\text{Tc}$  labeled leukocyte scan.



Figure 2a. Contrast enhanced axial CT image.

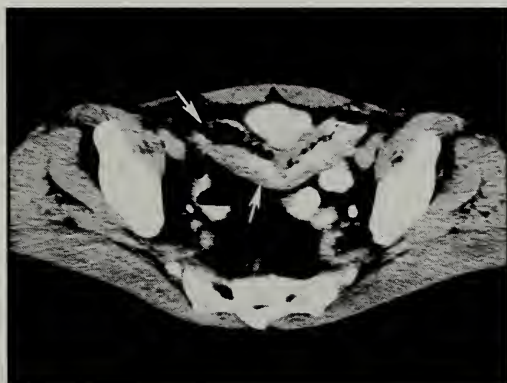


Figure 2b. Contrast enhanced axial CT image inferior to Figure 2a.

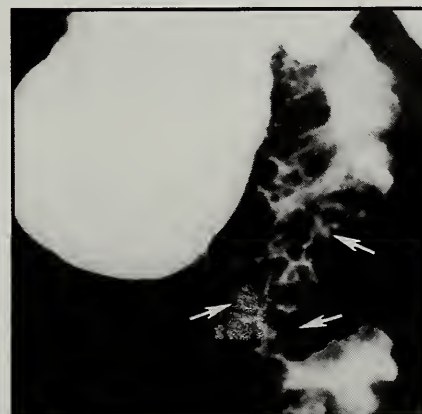


Figure 3. Spot view of terminal ileum from small bowel follow-through.

## History:

A 49 year-old male with a three day history of recurrent abdominal pain.



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# Crohn's Disease

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## Radiographic Findings:

The  $^{99m}\text{Tc}$  labeled leukocyte scan shows a linear band of increased uptake in the right lower quadrant (black arrows) in the region of the terminal ileum. CT images with oral and intravenous contrast demonstrates a circumferentially thickened terminal ileum (white arrows). There is no evidence of abscess, phlegmon, or adenopathy. Spot views of the terminal ileum from a small bowel follow-through shows nodular filling defects or the classic "cobblestoning" pattern (white arrows). No evidence of fistulous tract formation is seen.

## Discussion:

$^{99m}\text{Tc}$  (Technetium) labeled leukocyte scan are currently under research investigational protocol at several institutions nationwide awaiting FDA approval.  $^{99m}\text{Tc}$  labeling has higher resolution over  $^{111}\text{In}$  (Indium) labeling, which is currently FDA approved. This is secondary to the lower energy emission of the  $^{99m}\text{Tc}$  radiopharmaceutical. Moreover,  $^{99m}\text{Tc}$  labeling allows for imaging at two to six hours, instead of 18 to 24 hours with  $^{111}\text{In}$  labeling.

In Crohn's disease, leukocyte scanning is helpful to determine the extent of disease. Since Crohn's disease involves the mucosa of the ileum in 90% of cases, barium studies are sensitive for the early disease detection. CT is helpful later when bowel wall thickening occurs. Fibrofatty proliferation of the mesentery is also seen on CT. Complications include fistula formation, seen in 33% of cases, which is best detected by barium examinations. Small bowel obstruction, seen in 15%, is identified on abdominal uncommon, the serious complication of abscess formation is best determined by CT. Radiopharmaceutical labeled leukocyte scanning is sensitive for detection of focal bowel involvement, but not specific to discriminate from abscess formation.

## References

1. Eisenberg RL. Gastrointestinal Radiology 1990; 472-5.
2. Siegal BA, Proto AV, Theros EG. Nuclear Radiology 1990, 501-12.

---

*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Rudy L. Van Hemert, M.D., is a radiology resident at the University of Arkansas for Medical Sciences in Little Rock.*

*Contributor: Teresita Angtuaco, M.D., is the head of the Division of Imaging at the University of Arkansas for Medical Sciences in Little Rock.*



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# AMS Newsmakers

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Seven members of the Arkansas Medical Society Auxiliary represented Arkansas at the National AMSA Convention in Chicago recently. They were: **Mrs. Charles Rodgers (Rita)**, president; **Mrs. William Harrison (Sandy)**, president-elect; **Mrs. William Riley (Liz)**, health projects; **Mrs. Joe Stallings (Mary Ann)**, recording secretary; **Mrs. Jerry Holton (Gwen)**, legislation and AMA-ERF; **Mrs. Roger Cagle (Sharon)**, Northeast vice president; and **Mrs. Robert Pang (Peggy)**, Northwest vice president.

The efforts of the auxiliary's DWI project, "Is Dying Worth It?", was published in the July 1991 issue of *FACETS*, the AMA Auxiliary magazine. The cover contained a photo of "Black Jack," the creation of Arkansas Baptist High School senior Chris Hynes.

**Dr. Robert D. Dalby**, a family physician from Ashdown, was recently appointed as assistant clinical professor in the Department of Family and Community Medicine at the Area Health Education Center for the Southwest in Texarkana. The program is part of the University of Arkansas for Medical Sciences.

**Dr. William E. Harrison**, an obstetrician/gynecologist from Little Rock, has been elected chief of medical staff at Doctors Hospital in Little Rock.

**Dr. Thomas R. Hoberock**, a general surgeon from Harrison, was recently elected president of the Arkansas Chapter of the American College of Surgeons. Dr. Hoberock has been vice president of that organization for the past year.

**Dr. J.F. Kelsey**, the first board certified obstetrician in western Arkansas, has been honored with an endowment which will help support the obstetrical wing of the Nancy Orr Family Center at Sparks Regional Medical Center.

**Dr. Ann W. Maners**, a therapeutic radiologist from Little Rock, recently received a three year appointment from the American College of Surgeons Commission on Cancer as liaison physician for Central Arkansas Radiation Therapy Institute.

**Dr. James J. Pappas**, an otologist in private practice in Little Rock, has been elected to the board of the Deafness Research Foundation (DRF).

**Dr. Mayne Parker**, an ophthalmologist from Little Rock, has been elected chief of staff-elect of Doctors Hospital in Little Rock.

**Dr. Clair Price**, an ophthalmologist from Lake Village, was the winner of the Raymond and Mary Morris annual ophthalmology resident award for the best scientific presentation at a residents and alumni day meeting sponsored by the Department of Ophthalmology of the College of Medicine at the University of Arkansas Medical Sciences recently.

**Dr. Bascom P. Raney**, a retired physician from Jonesboro, has been honored with the establishment of a pre-medical scholarship at Arkansas State University in Jonesboro. The City of Jonesboro and the medical community recently observed "Bascom P. Raney Day" in recognition of his 37 years of service to the medical profession.

**Dr. Charles Rodgers**, a family physician from Little Rock, has been named a finalist in the American Academy of Family Physicians Family Doctor of the Year competition. A final winner will be named from among the ten by a national panel of judges.

**Dr. Harry P. Ward**, chancellor of the University of Arkansas for Medical Sciences, recently received an honorary doctor of science degree from Kaohsiung Medical College and the nation of Taiwan in recognition of his roles in medical education, research, and health care.

**Dr. Morton Wilson**, a Fort Smith urologist, recently retired from practice and is going to be working with the PRO, the peer review organization mandated by the federal government to keep track of medical costs and the quality of care.

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# News Release

*The Journal of the Arkansas Medical Society* regularly features announcements of personnel promotions, awards, and other changes as they happen in Arkansas medicine. In response to several requests, we offer the guidelines below. Following these should produce an easy to read release suitable for any publication. Send us your information today!

## FORMATTING YOUR NEWS RELEASE

- List a contact person with phone numbers where they can be reached if more information is needed.
- Use news release letterhead if you have it; otherwise, clearly identify the company or organization authorizing the news release.
- Use one side of 8 1/2 x 11 white paper. Good quality photocopies are fine since most editors assume you'll be sending the story to more than one outlet. If the release has been specially prepared for one editor, note it on the release.
- Indicate a release date - when you are requesting the story be used. If you don't use a release date, be sure to include the date (with the year) when the release was issued.
- Begin the story about half way down the first page. Leave adequate margins so editors have room to make notes.
- Double space the release.
- Type "-more-" at the bottom of each page if the story contains more than one page, except on the final page. Don't break paragraphs between pages; make sure each new page starts a new paragraph. The idea is to make your release easy for the editor to read quickly.
- Limit each paragraph to two or three short sentences. Paragraphs may contain only one sentence.
- Don't staple the pages.
- Mark the end of the release on the final page with what are considered traditional end-of-document indicators: center either "###" or "-30-" after the last paragraph on the last page.
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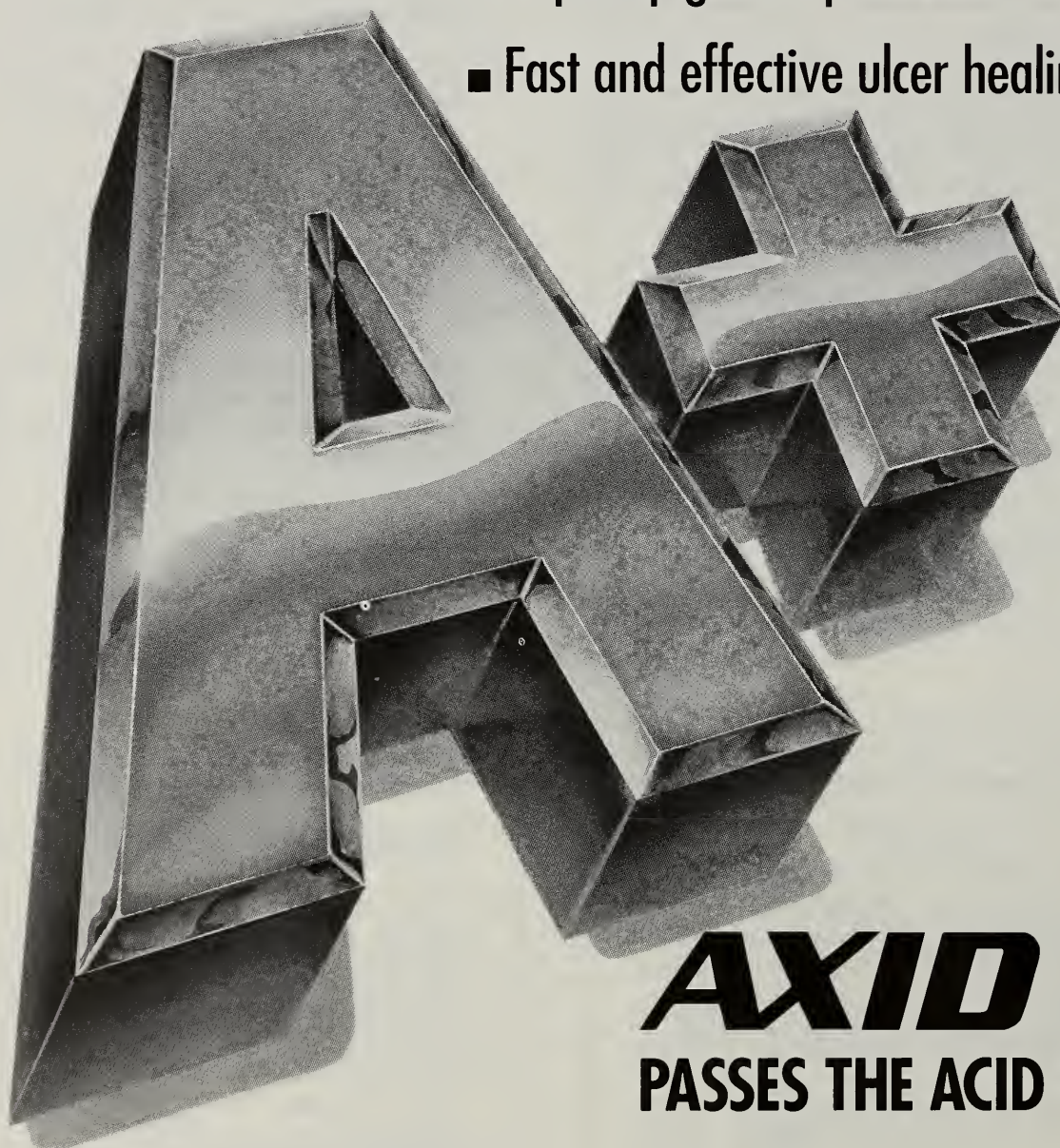


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**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions:**—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility:**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 60 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterodromal-like (EOL) cells in the gastric cryptic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C—**Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers:**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients:**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic—Hepatocellular injury** (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundices have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular:**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS:**—Rare cases of reversible mental confusion have been reported.

**Endocrine:**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic:**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental:**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity:**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other:**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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### References

1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request.



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# In Memoriam

## Robert K. Drange, M.D.

Robert Kirk Drange, M.D., a radiologist from Rogers, died Monday, July 1, 1991. He was 39.

Dr. Drange was a member of the Arkansas Medical Society, the American College of Radiology, the Radiologic Society of North America, the American Institute of Ultrasound in Medicine, and the American Medical Association.

Dr. Drange is survived by his wife, Christine; two daughters, Annelise and Kirsten; his father and step-mother, Robert O. and Mary Drange of Prairie Village, KS; and, his brother, Philip Drange of Tujunga, CA.

## Ralph Block Hamilton, M.D.

Ralph Block Hamilton, M.D., a family physician from West Memphis, died Thursday, August 1, 1991. He was 84.

Dr. Hamilton was the first chief of staff at Crittenden Memorial Hospital, a member of the Arkansas Medical Society and the Fifty Year Club, and past president of the Crittenden County Medical Society.

Survivors are his wife, Mabel Stacy Hamilton; a son, Ralph Hamilton Jr. of Germantown, TN; a sister, Wirta Smith of Marion; and four grandchildren.

## Vincent Orlando Lesh, M.D.

Vincent Orlando Lesh, M.D., of Fayetteville, died Monday, August 5, 1991. He was 85.

Dr. Lesh was a retired chief of staff physician at Washington Regional Medical Center and Fayetteville City Hospital and a World War II veteran.

Dr. Lesh was a member of the Washington County Medical Society, the Arkansas Medical Society and the Fifty Year Club, the American Medical Association, the Frisco System Medical Association, and an affiliate of the International College of Surgeons.

Dr. Lesh is survived by his wife, Dr. Ruth Lesh; a son, Vincent Lesh of San Marcos, CA; a daughter, Mrs. Earl Lee Chaddick of Fayetteville; a sister, Mrs. David Davis of Salem, NJ; three grandchildren; and a great-grandchild.

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# Medicine in the News

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## Health Care Access Foundation Update

As of July 1991, the Arkansas Health Care Access Foundation has provided free medical services to 2,997 medically indigent persons.

The program has 1,468 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## New Arkansas Laws Pertaining to Drugs

### *Disposal of Unwanted Non-Controlled Drugs and Medical Devices*

Arkansas law (Act 924 of 1991) prohibits the disposal or abandonment of non-controlled drugs and medical devices that are no longer usable or wanted, in such a manner that would be of danger to the public health or safety, or made available to persons without authority under law to possess them.

The law allows for the agents of the Department of Health to petition the courts to provide for the destruction of abandoned drugs at the expense of the claimant unless the claimant arranges for the proper destruction of such drugs according to procedures designed to eliminate the risk to public health and safety.

For assistance in disposing of unwanted drugs/devices, contact the Arkansas Department of Health, Pharmacy Services and Drug Control.

### *Anabolic Steroids - Now Listed as Schedule III*

Arkansas law (Act 570 of 1991) defines anabolic steroids as Schedule III controlled substances and subject to record keeping requirements of Section 6 "Rules and Regulations of the Arkansas Department of Health Pertaining to Controlled Drugs."

Every practitioner shall keep a record of such drugs received, administered, dispensed or used otherwise than by prescription. The records are to be kept in one consolidated system separately from all other records and in such a form that the information required is readily retrievable from patient records and ordinary business records.

## AMA Offers Fresh Advice for Physicians

Valuable financial planning ideas are available direct to physicians through a new and unique product - *Fresh Advice*. Published by the American Medical Association and Planning Focus, Inc., a Redmond, Washington-based publisher of legal educational programs for businesses and their professional advisors, *Fresh Advice* makes the best in

physician planning ideas available to you.

The 1991 edition of *Fresh Advice* features 12 practice and personal financial management discussions presented on audiocassette tapes. Each topic is presented in a clear and concise discussion, with the main ideas summarized in a printed outline. Discussions range in length from 12 minutes to 38 minutes. 1991 topics include:

1. Contracting with the new associate physician: nine important tips
2. How to fire the difficult staff employee
3. Physician buy-sell agreements: avoid the seven most common mistakes
4. Techniques to protect your personal assets from malpractice claims
5. A technique to admit the new partner - fairly and painlessly
6. An idea for eliminating retirement plan headaches in your practice
7. Keeping life insurance priorities straight for yourself and your partners
8. Providing better staff fringe benefits at less cost
9. Employee handbooks: how to avoid the six biggest mistakes made by physicians
10. A cure for your practice's sick leave policy
11. How to increase the real value of your life insurance
12. Estate planning: 16 points of concern

The 1991 *Fresh Advice* library is packaged in a book-size hard binder that facilitates sharing with colleagues. To order *Fresh Advice*, call the AMA at 1-800-621-8335 and request NL372491.

## Technology Resource Center Benefits the Disabled

Technology is having a profound effect on the lives of many people with disabilities. So amazing is this effect, that some severely disabled individuals are referred to as

being "technology dependent." A term which refers to the ability of technology intervention, in the form of computers, computer peripherals, assistive devices, environmental control units, and software, to assist in helping people with disabilities to become more independent.

In some cases, assistive technology becomes a prosthesis for physical abilities that have been lost or have degenerated because of disease or trauma or as the result of a congenital condition. For the severely disabled individual who lacks the motor ability to hold a pencil, specialized computer access can make the computer a writing prosthesis for this individual. For the individual who is non-speaking or has unintelligible speech, dedicated computers known as augmentative communication devices, may serve as a speech prosthesis.

For many disabled children computers and software allow them to access education, recreation, and even communication, often for the first time. Through computer access and specialized software, adults with disabilities can also access education and recreation. In addition, they may also gain some independence in controlling their environment and develop skills that are needed to enter, or in some cases, re-enter the workplace.

The Arkansas Technology Resource Center is based on the premise that "technology gives people with disabilities the power to do more." The Center provides "hands on" experience with computers, software, and assistive devices to people with disabilities, their families, professionals who work with them, and to others who are interested. In addition, the Center responds to requests for information on assistive technology, hosts technology workshops and vendor demonstrations, and provides technical and consulting services. A major program component of the Arkansas Technology Resource Center is specialized evaluation services and speech pathology treatment in augmentative communication and computer access.

#### **"A Good Hometown"**

##### **Practice Opportunity - Booneville, Arkansas**

Beautiful, Western Arkansas community of 4,000 seeks a Family Practice physician or an Emergency physician to either practice with three existing Family Practice physicians; or to provide evening emergency room and outpatient clinic coverage 2, 3, or 5 evenings per week. Interested physicians should send CV to:

Robert E. Baumann, Administrator

Booneville City Hospital

1200 West Main Street

Booneville, AR 72927

(501) 675-2800 (principals only please)

## **Free Medicare Supplement for Patients**

The Qualified Medicare Beneficiary (QMB) program is a free Medicare supplement for low-income Medicare beneficiaries. This program pays the beneficiaries' Part B premiums (\$29.90 per month), plus their deductibles and

co-payments. It is administered by the Arkansas Department of Human Services, and financed by Medicaid funds. As many as 55,000 elderly Arkansans may be eligible for the program, but only 4,386 were enrolled in early May.

To be eligible, persons must have Medicare and their total income must be no greater than \$571.66 for a single person or \$760.00 for a couple. Their resources (assets) must be no greater than \$4,000 for a single person and \$6,000 for a couple. Their home, household goods, and car are not counted as resources. Applications can be made at the county DHS office.

Providers must have a Medicaid number to receive reimbursement under the QMB program, and you must accept assignment for Part B claims. Participation does not obligate you to treat Medicaid patients.

For more information about QMB, including a poster for you waiting room and a sample leaflet for potentially eligible patients, contact Arkansas Seniors Organized for Progress at 661-1401. Patients can be referred to the Area Agency on Aging for assistance in applying.

## **FREEMYER COLLECTION SYSTEM**

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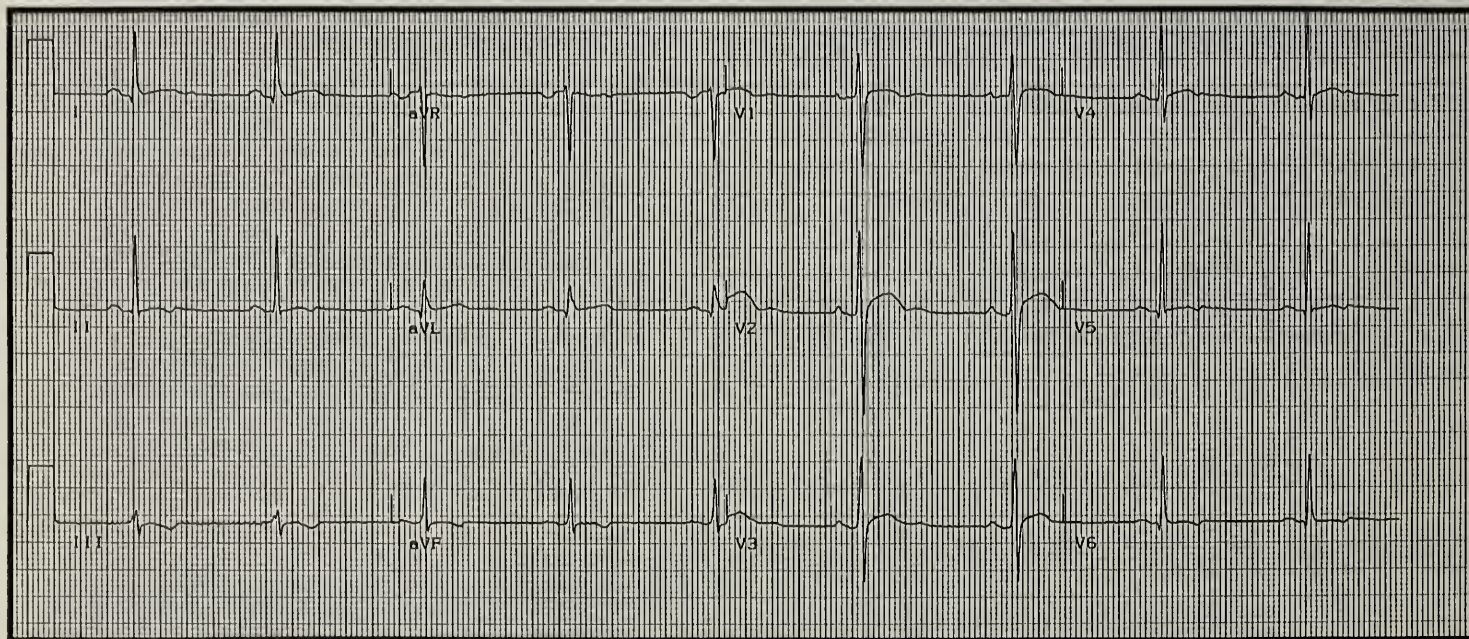


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## CLINICAL HISTORY:

This record was obtained from a 30 year-old black man with an intermittent history of chest pain. This only risk factor for coronary disease was a possible history of diabetes mellitus. There was no history of cocaine or other illicit drug ingestion either at the time of presentation or in the past. The patient was given thrombolytic therapy and referred for further evaluation.



## DISCUSSION:

The most striking abnormality of this ECG is the apparent ST elevation in the right precordial leads with T wave inversion in the remaining leads. The pattern could be interpreted as diffuse acute injury. In the absence of tachycardia and PR segment shifts, the diagnosis of acute pericarditis is unlikely. The convex upward pattern of the ST segments in the right and mid-precordial leads are not usually observed in the syndrome of early repolarization, but may on occasion be present. This patient had no evidence of structural heart disease. The results of 2D echocardiographic and Doppler examination of the heart as well as left heart catheterization and coronary cineangiography were entirely normal. There were no electrolyte abnormalities nor was there any evidence of drug ingestion. This electrocardiographic pattern has remained unchanged over a period of weeks, supporting the conclusion that this ECG represents a normal variant.





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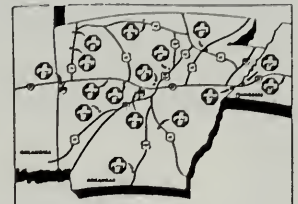
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S.M. Young, M.D.

F.R. Shrader, M.D.



# Things To Come

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## October 2-12

**Allergy Abroad.** Hong Kong & Guilin, China. Sponsored by the Division of Allergy and Immunology and the Office of Continuing Medical Education, Washington University School of Medicine in St. Louis, MO. Category I credits available. For more information, contact Cathy Caruso at (800) 325-9862.

## October 4-5

**1st National Symposium on Day Care for Children.** The Ritz-Carlton, Pentagon City, Arlington, VA. Sponsored by the American Academy of Pediatrics and the Institute for Pediatric Service of Johnson & Johnson Consumer Products, Inc. Category I credits available. Fees: \$250.00, physicians; \$150.00, nurses, allied health professionals, educators; \$100.00 residents, graduate students, others in training. For more information, call Jim Dettre at (908) 874-1631.

## October 13-17

**Joint Meeting of the American Academy of Ophthalmology and the Pan-American Association of Ophthalmology.** Anaheim Convention Center, CA. Sponsored by the American Academy of Ophthalmology. For more information, contact Linda Whitfield, (415) 561-8500.

## October 24-26

**Sexual Desire Disorders: Everything You Wanted to Know But Lacked the Desire to Ask.** Holiday Inn Crowne Plaza, Kansas City, MO. Sponsored by The Menninger Clinic. Fees: \$235 per person; \$195 per person for two or more from the same company. For more information, contact Brenda Vink at (800) 288-7377, ext. 5991.

## October 28-31

**Primary Care Update.** Hyatt Regency New Orleans, LA. Sponsored by the Interstate Postgraduate Medical Association of North America. Category I credits available. Fees: \$225, advance registration; \$250, on site registration; \$35, residents & interns; \$50, allied health professionals. For more information, call (608) 257-1401.

## November 6-8

**Comprehensive Management of HIV Disease: A Clinical Preceptorship for Physicians.** Sponsored by the Delta Region AIDS Education and Training Center at the

Louisiana State University School of Medicine, New Orleans. For more information, contact Gwendolyn Foxworth or Daphne LeSage at (504) 568-3855.

## November 7-8

**National Conference on Alcohol & Other Drug Abuse: Changing Lives Through Research & Treatment.** Meharry Medical College, Nashville, TN. Sponsored by the Meharry Medical College. For more information, call (800) 669-1269.

## November 9-14

**44th Annual Meeting of the American Association of Blood Banks.** Baltimore Convention Center, Baltimore, MD. For more information, contact Marcia Lane at (703) 528-8200.

## November 16-19

**SMA's 85th Annual Scientific Assembly.** Georgia World Congress Center & Atlanta Hilton & Towers, Atlanta, GA. Sponsored by the Southern Medical Association. For more information, call (800) 423-4992.

## December 7

**8th Annual Clinical Update in Pulmonary Medicine.** Caesars Hotel, Atlantic City, NJ. Sponsored by the Department of Pulmonary Medicine, Deborah Heart and Lung Center of the Center for Bio-Medical Communication, Inc. Category 1 CME credits available. For more information, contact Robert Silver at (201) 385-8080.



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# Keeping Up

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## **1991 Sports Medicine Update Care of the Injured Athlete**

*September 14, 7:30 a.m.-5:00 p.m. Holiday Inn West, Little Rock.* Presented by Arkansas Sports Medicine and Orthopaedic Center, P.A. Sponsored by the Arkansas Academy of Family Physicians, Arkansas Chapter, American Academy of Pediatrics, and the Arkansas Athletic Trainers Association. Eight hours CME credits offered. For more information, contact Kandee Moser at (501) 225-0080.

## **Northwest Arkansas Regional Conference on Perinatal Care**

*September 20, 1:30 p.m., Holiday Inn, Springdale.* Sponsored by UAMS College of Medicine. Fees: \$50. Four hours Category I credits offered.

## **AHEC-Pine Bluff ACLS Course**

*September 26-29, Jefferson Regional Medical Center, Pine Bluff.* Sponsored by UAMS College of Medicine. Fees: \$150. Sixteen hours Category I credits offered.

## **Perinatal Care in Arkansas: State of the State**

*October 4, 7:30 a.m., UAMS Education II Building G-137, Little Rock.* Sponsored by UAMS College of Medicine. Fees: \$20. Six hours Category I credits offered.

## **Working with Different People Differently**

*October 15, 9:00 a.m.-3:30 p.m., Arkansas Services Center, Jonesboro.* Sponsored by the George W. Jackson Community Mental Health Center. Fees: \$20, pre-registration; \$25, at the door. For more information, call (501) 972-4014.

## **Chronic Lymphocytic Leukemia: 1991**

*October 18, 12:00 noon, St. Vincent Center for Health Education.* Sponsored by St. Vincent Cancer Center. CME credit available. Lunch is provided.

## **Arkansas Physicians Opportunity Fair**

*October 24, University of Arkansas for Medical Sciences.* More information will be forthcoming. For more information, contact Tom South at (501) 686-5813.

## **Dying, Death & Grieving: A Social Process**

*November 5, 9:00 a.m.-3:30 p.m., Arkansas Services Center, Jonesboro.* Sponsored by the George W. Jackson Community Mental Health Center. Fees: \$20, pre-registration; \$25, at the door. For more information, call (501) 972-4014.

## **The Seasonal Child**

*December 3, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building.* Sponsored by Arkansas Children's Hospital. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.*

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC*  
*Medical Grand Rounds, Fridays, 12:00 noon, VAMC*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium*  
*Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457*

*Infectious Disease Conference*, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Dunkerton/AP&L room. Lunch provided  
*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Pathology classroom. Lunch provided  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon. Lunch provided  
*Sleep Disorders Case Conference*, every other Thursday, Video Production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon. Sandwich buffet served

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., conference room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

### **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m., 2nd/4th Thursdays, 4:00 p.m., UAMS Ed. Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293



*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
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*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

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*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
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*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
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*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

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*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

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*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center



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*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th & 5th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
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*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
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*Advertising Agencies in italics*

American Physicians Insurance Exchange .....	inside front
Arkansas Express Claims .....	182
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Central Arkansas Rehabilitation Hospital ....	back cover
<i>Fowler Martin &amp; Associates</i>	
Collom & Carney Clinic Association.....	203
Eli Lilly & Company .....	196
<i>Garrison, Jasper, Rose &amp; Company</i>	
Eli Lilly & Company .....	197
Tommy Farrell Associates .....	165
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	201
Freemyer Collection Systems .....	199
Medical Protective Company .....	177
<i>Ferguson Advertising, Inc.</i>	
Medical Protective Company .....	190
Mediquik Walk-In Clinics .....	201
MED/PAC - Formcraft of Arkansas, Inc. ....	169
MEDX .....	203
Mississippi Methodist Rehab Center .....	174
Palisades Pharmaceuticals, Inc. ....	185
<i>Design &amp; Advertising</i>	
Radiology Consultants .....	170
Rather, Beyer & Harper .....	165
State Volunteer Mutual Insurance Company .....	166
<i>The Maryland Group</i>	
U.S. Air Force .....	193
<i>Bozell, Inc.</i>	
University Cardiothoracic Surgery .....	165

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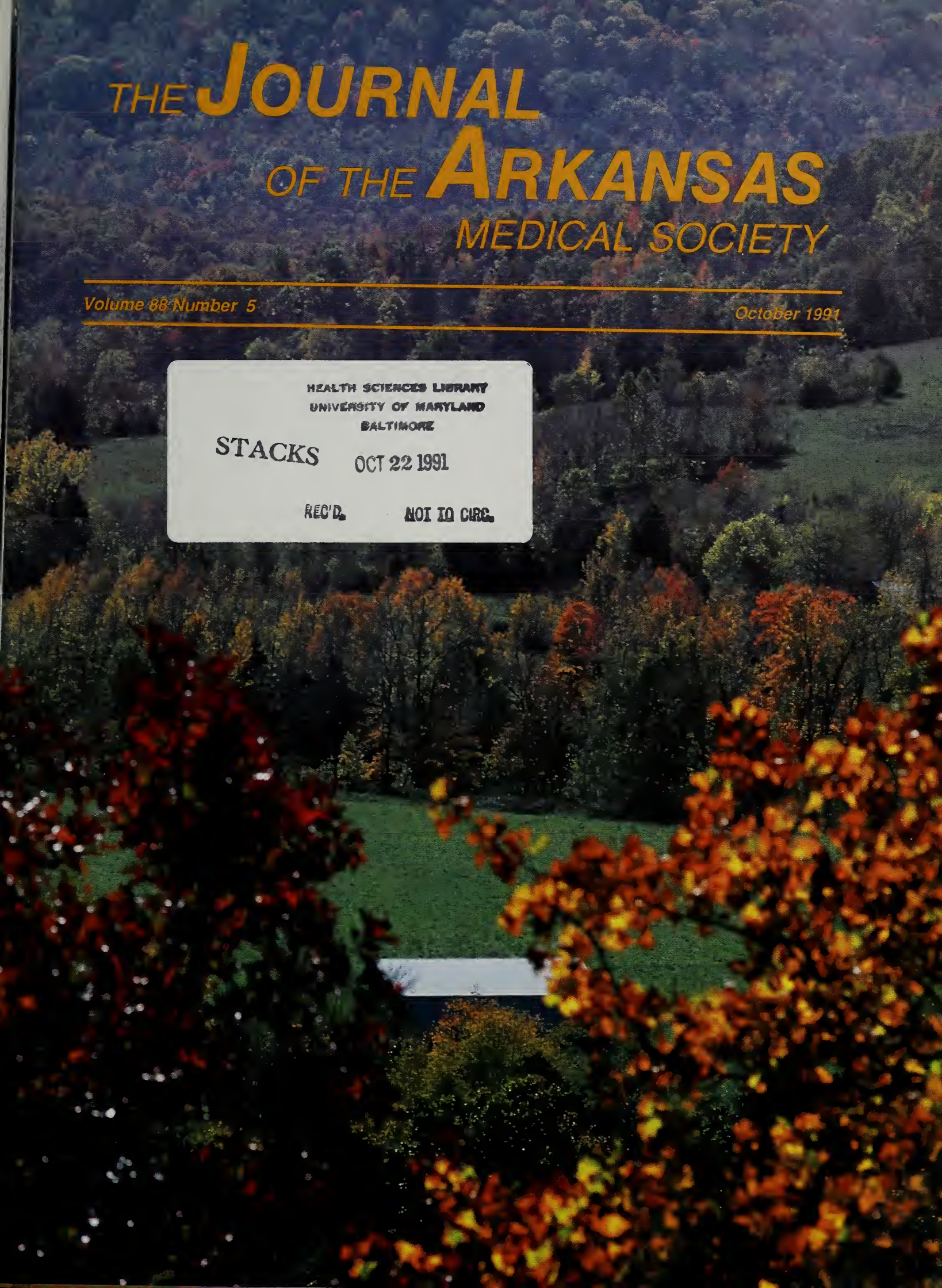


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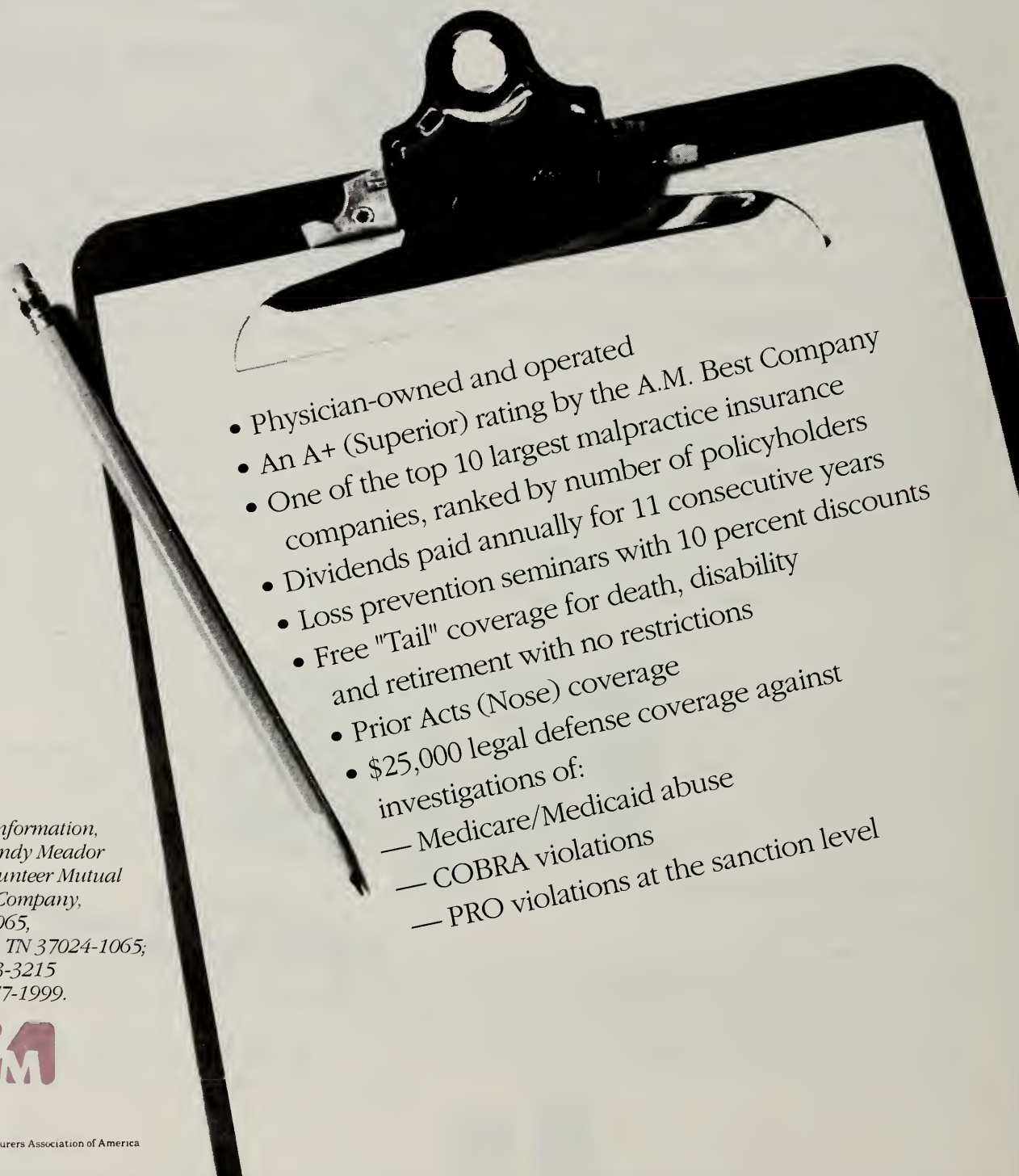
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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 5

October 1991

## CONTENTS

### FEATURES

- |     |   |
|-----|---|
| 212 | <b>Biomedical Research at UAMS</b><br><i>Editorial</i><br>I. Dodd Wilson, M.D.  |
| 215 | <b>Experience with the Kimray-Greenfield Inferior Vena Caval Filter</b><br>Tamara S. Hlavaty, M.D., Timothy C. McCowan, M.D., Ernest J. Ferris, M.D., et al |
| 219 | <b>Proteinuria in Children</b><br>Eileen N. Ellis, M.D., Nancy R. Kelly, M.D.   |
| 225 | <b>How to Unveil Legislative Initiative</b><br>Harold L. Jensen, M.D.   |
| 228 | <b>Recommendations for Preventing Transmission of HIV and HBV to Patients During Exposure-Prone Invasive Procedures</b><br>Center for Disease Control       |
| 234 | <b>A Missed Opportunity?</b><br>J. Kelley Avery, M.D.   |

### DEPARTMENTS

- |     |                                       |
|-----|---------------------------------------|
| 232 | <b>AIDS in Arkansas Statistics</b>    |
| 236 | <b>ECG of the Month</b>               |
| 238 | <b>New Members</b>                    |
| 241 | <b>Radiological Case of the Month</b> |
| 245 | <b>AMS Newsmakers</b>                 |
| 246 | <b>In Memoriam</b>                    |
| 248 | <b>Resolution</b>                     |
| 250 | <b>Medicine in the News</b>           |
| 252 | <b>Things to Come</b>                 |
| 256 | <b>Keeping Up</b>                     |

Cover photo by A.C. Haralson of the Arkansas Department of Parks & Tourism.



# Biomedical Research at UAMS

I. Dodd Wilson, M.D.

**I**n this space, I have discussed the impediments to attracting talented people into our profession, the high level of indebtedness that UAMS medical students accrue, and the need to induce medical students to practice in rural Arkansas. The following represents a substantial shift in topic.

Taking shape on Elm Street across from the UAMS campus is the new Biomedical Research Building funded by the State Legislature. This building will contain almost as much research space as was present at UAMS in 1980. With plans in progress to develop the Arkansas Children's Hospital and the Jones Center for Eye Research, and with the openings of the Arkansas Cancer Research Center, the McClellan Memorial VA Medical Center research facility, and the Sturgis Building at Arkansas Children's Hospital, the aggregate of space will greatly enhance research potential of the College of Medicine. This modern space will support sophisticated biomedical research. And this is important. The mission of UAMS is "to provide comprehensive educational opportunities for students of the health professions in a stimulating environment of basic and clinical research, integrated with the delivery of primary, secondary and tertiary health care services." Medical schools emphasize three missions: serving, teaching and searching. The College of Medicine at UAMS has concentrated on fulfilling its educational mission and providing service to the citizens of Arkansas, both laudatory goals. Research has not been emphasized. Scholarship and inquiry improve the instructional environment through informed faculty and more challenging educational opportunities for students. Because of improved educational opportunities and a stronger faculty, those students are attracted who will be better physicians, or in the case of our graduate programs, better scientists for the State of Arkansas. Research has great intrinsic value because it leads to new knowledge and the relief of human disease and suffering. Our medical practice puts the results of research onto action every day.

Research is to basic science departments as clinical medicine is to the clinical departments. With facilities to support research, it is possible to recruit top-notch basic scientists and teachers. Medical education increasingly emphasizes skills needed for lifelong learning. Teaching these skills requires small group and one-to-one interactions,

problem-based learning and computer-assisted instruction, all of which are time-consuming. These curricular enhancements are difficult to accomplish with the small basic science departments at UAMS. Teaching will improve because of the additional research space that allows us to expand our faculty.

The region benefits economically because research is also a business. It brings well-educated and effective scientists into the community. Successful research will attract large amounts of new revenue to Arkansas. This money will be spent in and then multiply in the Arkansas economy. Research leads to the development of biotechnology transfer and new businesses within the state. An increasing number of patents are acquired by UAMS and our faculty each year.

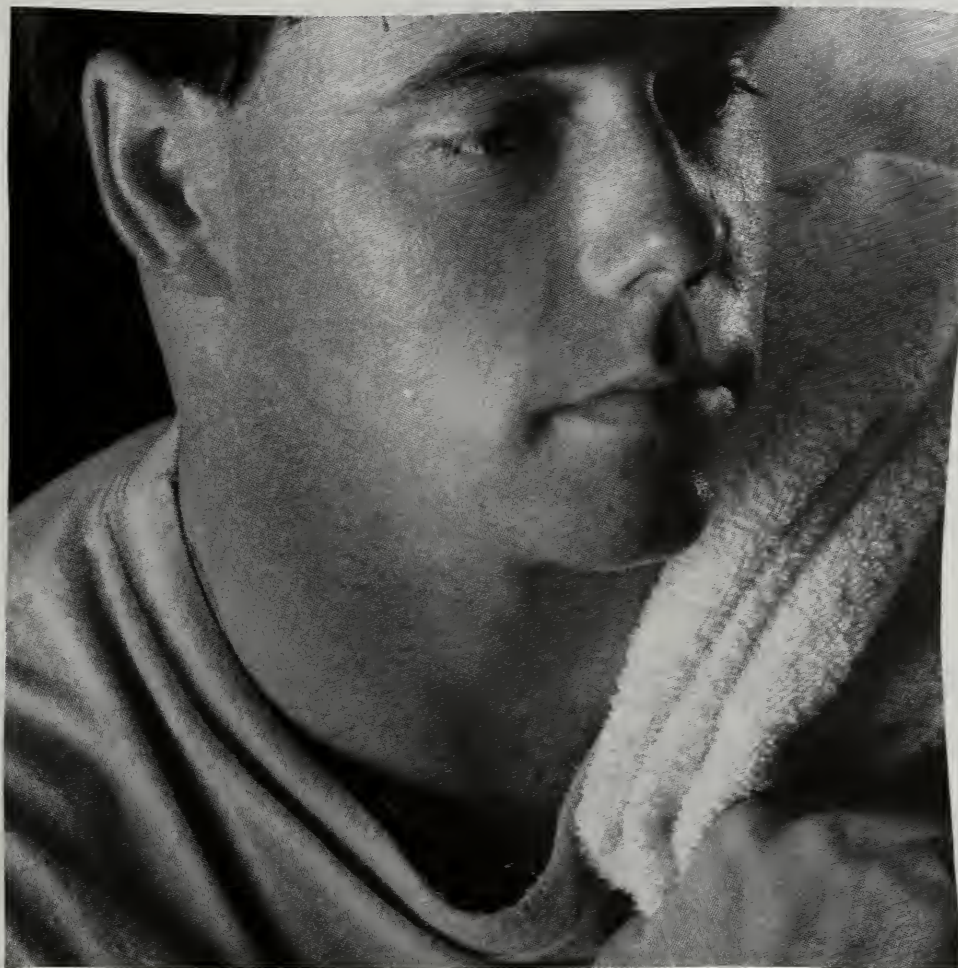
Goals at UAMS are 1) to double the present level of research funding within four years, 2) to equip the faculty with state-of-the-art research equipment and facilities, and 3) to concentrate physical, human and fiscal resources in targeted areas for programmatic development, thereby attaining selective excellence. The goal to double research funding has been accomplished. The facilities the College of Medicine will have available within two to three years make UAMS very competitive with regional medical schools. Large pieces of equipment are difficult to purchase from research grants and are purchased from pooled resources. During the past several years, we have purchased core equipment for molecular biology, electron microscopy, nuclear magnetic resonance spectroscopy, research flow cytometry, and gas-chromatography/mass spectrometry using a combination of practice and federal funds.

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# Experience with the Kimray-Greenfield Inferior Vena Caval Filter

Tamara S. Hlavaty, M.D., Timothy C. McCowan, M.D.,  
Ernest J. Ferris, M.D., Danna K. Carver, R.N., Diana L. Harris, B.S.\*  
Robert W. Barnes, M.D.\*\*

**T**housands of people in the United States suffer from the morbidity and mortality of pulmonary embolism (PE). It is estimated that as many as 200,000 deaths occur annually from PE despite widespread use of anticoagulant therapy.<sup>1</sup> The mortality rate is estimated to be 30% for untreated PE.<sup>2</sup> Reports indicate that the proper use of anticoagulant therapy decreases the mortality to 8-10%.<sup>3</sup>

Although anticoagulant therapy is the preferred treatment for PE, mechanical interruption of the inferior vena cava (IVC) with a vena caval filter is sometimes necessary to prevent PE.<sup>2</sup> Candidates for caval interruption are patients with contraindications or complications of anticoagulant therapy, or patients who fail systemic anticoagulation. Rarely, a filter will be placed in high risk patients on a prophylactic basis.

The Kimray-Greenfield (KG) IVC filter has been shown to be effective and safe at many institutions.<sup>4,5,6</sup> We reviewed to radiologic and clinical data on 39 patients in whom the KG filter was placed at the University of Arkansas for Medical Sciences.

## Patients and Methods

Thirty-nine KG filters placed at the University of Arkansas for Medical Sciences during the period from January 1984 until December 1988 had sufficient radiologic and/or clinical data for analysis. Twenty-nine filters were inserted via the right internal jugular vein during surgical cut-down, nine were placed percutaneously via right femoral vein, and one was placed via the right renal vein immediately following a right nephrectomy. All placements were accomplished by radiologists assisted by surgeons.

The group consisted of 21 females and 18 males. The average age was 56 years (range: 26-88 years). Indications for filter placement were: contraindication to anticoagulation in 27, failure of anticoagulation in 10, and prophylactic treatment for pulmonary embolism in two. At the time of this report, 20 patients were living, 14 were known dead, and five patients were lost to follow-up.

All but two patients had an abdominal radiograph following filter placement. Eleven patients were followed with abdominal radiographs only. Radiologic studies obtained after placement included: abdominal radiograph (N=37), abdominal computed tomography (N=17), inferior vena cavogram (N=5), extremity venogram (N=6), venous duplex sonography (N=3), and pulmonary arteriography (N=1). Some patients had more than one imaging study. Other imaging studies which mentioned filter placement included: cystograms, magnetic resonance imaging of the abdomen, excretory urograms, lumbar spine series, upper and lower gastrointestinal studies, arteriograms, and chest radiographs. The average length of radiologic follow-up was 15 months (range: 1-61 months). Clinical follow-up was also available on 14 patients.

## Results

The most frequent complication following filter insertion was lower extremity deep vein thrombosis (DVT). The overall incidence of DVT in the group was 15% (6/39). Two of the six cases occurred following percutaneous placement, and four followed surgical placement. DVT was confirmed by venogram in three cases, CT in two cases, and duplex sonography in one case. The time from filter placement to documented DVT ranged from three days to 17 months.

There was one documented case of recurrent PE among the group. The recurrent PE may have contributed to the patient's death. The indication for filter placement was recurrent PE despite adequate anticoagulation. Following filter insertion, a post-placement abdominal radiograph noted

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the filter to be at the bifurcation of the IVC. The patient died two weeks after placement. Cause of death was documented as ventricular arrhythmia and cardiomyopathy. Autopsy revealed encasement of the filter by thrombus and multiple, small pulmonary emboli in varying stages of resolution.

Penetration of the vena cava by the filter was documented in two asymptomatic patients on CT. One penetration involved two legs of the filter which was tilted 10 to 16

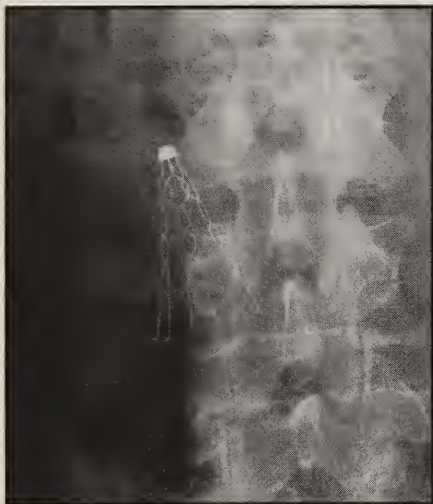


Figure 1a. Abdominal radiograph demonstrates the KG filter to be tilted in the IVC with slightly prominent leg spread.

degrees. The second penetration involved all six legs of the filter (Figure 1). The depth of penetration was estimated at 5-6mm per leg. No involvement of the aorta was noted, but small bowel penetration could not be excluded. The patient remained asymptomatic at 61 month follow-up.

Bleeding from the puncture site one day following percutaneous placement was noted in one case.

The patient was not receiving anticoagulation therapy. The bleeding was controlled by manual compression, no transfusions were required, and there were no further sequelae.

No significant filter migrations occurred in the study group. One filter was noted to be in the left common iliac vein immediately after placement (Figure 2).

## Discussion

The results obtained from this retrospective study compare favorable with the 12 year study conducted by Green-

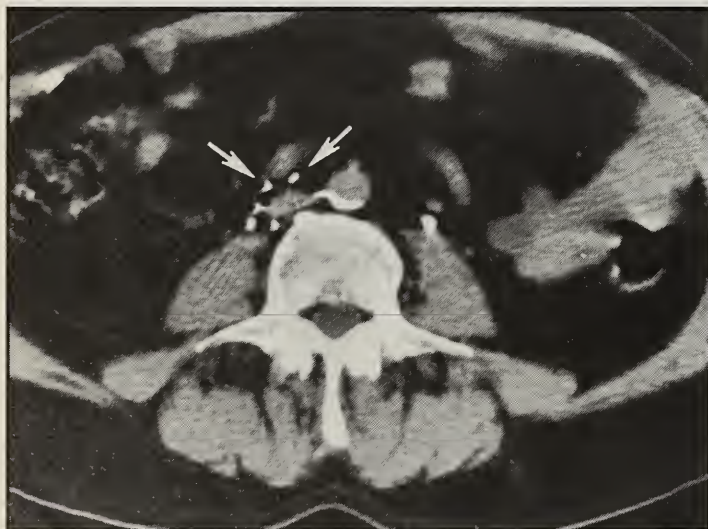


Figure 1b. Computed tomography of the abdomen reveals penetration of the IVC by all filter legs (arrows).

field.<sup>4</sup> The most common complication noted in this series was lower extremity DVT which was documented in six patients. It would be misleading, however, to attribute all these cases directly to the filter since four cases occurred after placement via the internal jugular vein and some cases were recognized several months after filter insertion. Primary or recurrent DVT related to the patients' underlying coagulation problem should strongly be considered as a major responsible factor.

During the time period studied, most filters (77%) were placed via surgical cut-down which is consistent with early experiences with IVC filters.<sup>4,7,8</sup> Almost all filters are now inserted percutaneously via routes including the right and left femoral veins, right internal jugular vein, and the right external jugular vein. This increased utilization of percutaneous placement rather than surgical placement is being observed nationwide. The increased use of percutaneous filter insertion has prompted the selection of filters with small introduction profiles such as the modified titanium Greenfield, Vena-Tech (LGM), Simon nitinol, and Bird's Nest instead of the KG filter.<sup>9,10</sup>

All vena caval filters warrant clinical and radiologic follow-up for proper patient care. The schedule we recommend for asymptomatic patients is an anteroposterior and lateral abdominal film and clinical exam at one month and six months post-insertion and then yearly. The radiograph is examined for indications of possible filter movement, perforation of the caval wall, caval stenosis, and filter disruption. The patient is examined for signs or symptoms of recurrent PE, caval occlusion, and extremity DVT. Patients should be telephoned at least twice yearly to evaluate potential problems such as new onset of leg edema, new and unusual shortness of breath, or recent onset of chest pain. If the patient is symptomatic or potential problems are noted on the abdominal radiograph, the patient is scheduled for the imaging exam that will best yield a diagnosis.<sup>11</sup> This may be duplex sonography, CT of the abdomen, venography, ventilation/perfusion lung scan, or an inferior vena cavogram. More frequent follow-up is indicated in any patient with symptoms related to the IVC filter or its placement.

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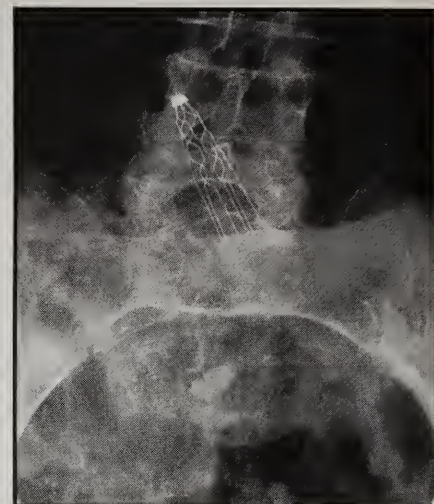


Figure 2. The unusual position of the KG filter indicates placement in the left common iliac vein.



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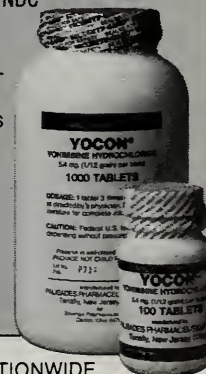
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

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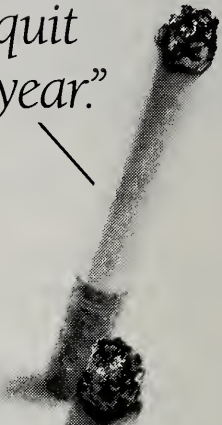
*"Nah,  
I've smoked  
for  
30 years.  
It's too late."*




*"I've tried a  
million times,  
but I just  
can't."*



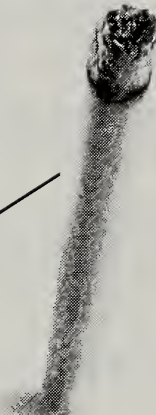
*"I'll  
quit  
next  
week."*




*"I'll quit  
next year."*



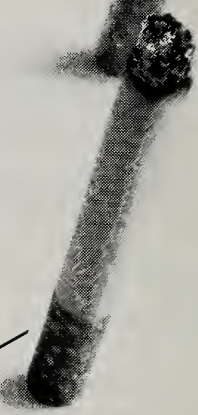
*"What difference does  
it make? I'm already  
52 years old."*



*"It's one of the  
few pleasures  
I have left."*



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# Proteinuria in Children

Nancy R. Kelly, M.D.\*

Eileen N. Ellis, M.D.\*\*

**P**roteinuria was first recognized by Richard Bright in 1827 and was defined as the excretion of abnormal quantities of protein in the urine. Because this can be an important laboratory hallmark of renal disease, identifying and quantifying urinary protein has become important in assessing for renal dysfunction. Physiologic proteinuria accounts for the excretion of 30-45 mg of protein daily in the urine of normal adults, with 150 mg a day being the upper limit of normal during usual activity.<sup>1</sup>

In infants and children, physiologic proteinuria varies with age. This is due to differences in body surface area and changes in normal renal physiology that occur with age. Miltenyi<sup>2</sup> studied 130 healthy children, aged five days to 16 years and determined normal ranges of urinary protein excretion for various groups (Table 1). This study showed that normal daily urinary protein excretion expressed in mg/m<sup>2</sup> decreases with increasing age.

## Composition of Urinary Proteins

The composition of proteins normally found in healthy patients is approximately 60% normal plasma proteins and the remaining 40% is made up of protein originating from renal and urogenital tissues.<sup>3</sup> Of the plasma proteins in urine, albumin makes up the largest portion and actually comprises about 40% of the total protein excreted. The amount and composition of urinary protein results from the interplay between glomerular filtration and tubular reabsorption of filtered protein.<sup>1</sup> Normally the glomerular capillary membrane acts as a barrier to the passage of protein into Bowman's Space. The glomerular capillary wall is made up of the endothelial layer, basement membrane and epithelial layer. It is the structure of the epithelial layer which acts as a size

barrier to restrict protein filtration. Electric charge also restricts filtration of certain proteins.<sup>4</sup> The glomerular capillary wall has a net negative charge which acts to repel the negative charge of proteins such as albumin resulting in restriction of protein filtration. Thus, size and charge of particles are important factors in determining whether or not a protein is filtered. Maintaining the integrity of structure of the capillary wall and the electrical charge are crucial in preserving an effective barrier to the passage of protein.<sup>4</sup>

**Table 1.**  
**Normal Daily Urinary Excretion of Protein (mg/m<sup>2</sup>)**

Age	Mean	Range
5 - 30 days (premature)	182	88-377
7 - 30 days (full term)	145	68-309
2 - 12 months	109	48-244
2 - 4 years	91	37-223
4 - 10 years	85	21-234
10 - 16 years	63	22-181

Tubular reabsorption is the other process which plays a role in determining the amount of protein which is excreted in the urine.<sup>5</sup> Small molecular weight proteins that are filtered through the glomerular capillary wall are usually reabsorbed by the proximal renal tubule. When abnormal amounts of protein appear in the urine on repeated exams, it can usually be attributed to one of three mechanisms - glomerular, tubular or overflow proteinuria.

## Pathophysiology of Abnormal Proteinuria

Glomerular proteinuria occurs when there is an increase in permeability of the glomerular capillary wall to proteins. This can be due to either a defect in the size barrier or the charge barrier. Once the charge barrier is lost, albumin,

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**Table 2.**  
**Overflow Proteinuria**

- \* Lysozymuria in nonlymphatic leukemia
- \* Bence Jones (light chain) proteinuria in multiple myeloma
- \* Hemoglobinuria in intravascular hemolysis
- \* Myoglobinuria in rhabdomyolysis
- \* Amylasuria in acute pancreatitis

which is normally restricted by charge, can easily cross the glomerular capillary wall and be excreted into the urine. Thus, albumin is the most common protein excreted in glomerular proteinuria. Some disease states result in loss of the size barrier of the glomerular capillary wall. When the size barrier is disrupted, excretion of larger molecular weight proteins such as IgG and transferrin may be seen.<sup>1,4</sup>

Tubular proteinuria occurs when small molecular weight proteins that have been filtered by the glomerulus are unable to be reabsorbed due to tubular injury.<sup>1</sup> The marker of tubular proteinuria is B<sub>2</sub>-microglobulin, a protein associated with histocompatibility surface antigens of cells. Usually this form of proteinuria is more mild than glomerular proteinuria with only one to two grams of protein excreted daily in the urine. The increased protein excretion seen in newborns is probably tubular in origin.<sup>2</sup> Newborns have immature renal tubule cells that are not as efficient in protein reabsorption compared with an older child.

Overflow proteinuria occurs when there is an overabundance in plasma of certain proteins whose molecular characteristics allow easy passage across the glomerular capillary wall (Table 2).<sup>1</sup> This type of proteinuria proves that the ability of tubules to reabsorb filtered protein is limited.

Proteinuria may also occur transiently due to more benign and self-limited causes such as fever, seizures, epinephrine administration or stress (Table 3).<sup>6</sup> This type of proteinuria is probably glomerular in origin. However, it is most likely not due to altered permeability of the glomerular capillary wall, but instead to hemodynamic changes, such as decreased renal plasma flow.

## Epidemiology of Childhood Proteinuria

Due to the many pathologic and benign causes, proteinuria is a fairly common finding in pediatrics. Dodge<sup>7</sup> conducted a five year study in Galveston, Texas from 1968-72 and examined urinalyses of school-aged children. Prevalence of proteinuria in two out of three urine specimens varied with both age and sex from 3-57%.<sup>7</sup> From this study, it was concluded that transient proteinuria is very common, but that persistence of proteinuria is not.

Children who were identified in this study as having persistent proteinuria were advised to seek medical follow-

up. Interestingly, of all the children who had proteinuria and were evaluated by their physician, only seven were felt to have significant renal disease which included nephrotic syndrome, chronic pyelonephritis, structural urinary tract abnormalities, and glomerulonephritis. This study was enlightening because it showed that transient proteinuria is quite common, but fortunately in most children it is not associated with underlying renal disease. Similar results were also found in a Finnish study done in 1982.<sup>8</sup> Nevertheless, identifying proteinuria is important so that those few patients with renal abnormalities may be identified.

## Assessing Proteinuria

Many methods are available for assessing proteinuria.<sup>9,10</sup> The two most common are the colorimetric (dipstick) and turbidimetric (precipitation) methods. Colorimetric or dipstick methods rely on the observation that proteins in solution will cause certain pH indicators to exhibit colors that are different from those that occur at the same pH in the absence of protein. The intensity of the color change is roughly proportional to the protein concentration. Dipstick methods are inexpensive and easy to use, but there are several drawbacks. The strips react preferentially with albumin and are relatively insensitive to globulins and Bence-Jones proteins so that false negative results can be seen in the presence of these proteins. False positives are common and are seen with highly buffered urine, or urine containing heavy mucous, blood, pus, semen or vaginal secretions. For this reason it is advisable to always collect clean catch urinalyses to avoid obtaining a urine sample contaminated with body secretions that might give false positive results for protein.

**Table 3.**  
**Causes of Transient Proteinuria**

- \* Fever
- \* Strenuous Exercise
- \* Emotional Stress
- \* Extreme Cold
- \* Epinephrine Administration
- \* Abdominal Surgery
- \* Seizures

In many hospital laboratories, when a dipstick test is positive at the level of trace or greater, the SSA method is performed.<sup>9,10</sup> The SSA or sulfosalicylic acid method, is a type of turbidimetric analysis. These tests depend on the visual detection of turbidity after protein in solution is precipitated by strong acid. The turbidity of the solution is roughly proportional to the protein concentration. This test is more accurate than colorimetric tests because all classes of proteins are detected. Drawbacks with this method are false negatives with very dilute or highly buffered urine, and false



positive in children who have received high doses of penicillin, sulfa drugs or radio-opaque dyes.<sup>8</sup> A problem with both the dipstick and SSA methods is that urine concentration can greatly affect the result, so that urine flow rate must be taken into account.

## Evaluation of a Child with Proteinuria

Once it has been determined that a child has persistent proteinuria, with more than two urinalyses positive for protein, further evaluation is indicated.<sup>6</sup> The first step should include a detailed medical history with special emphasis on recent urinary or respiratory infections which might indicate a chronic pyelonephritis or a post-infectious glomerulonephritis. A change in weight or the presence of edema might indicate nephrotic syndrome. Urinary complaints such as dysuria, oliguria or frequency should be noted. The presence of skin lesions or joint manifestations might indicate Systemic Lupus Erythematosus or Henoch Schonlein Purpura. Family history is also vital, paying special attention to a history of renal disease and hypertension. With a family history of hearing loss, Alport's syndrome should be considered.

Physical exams should be complete and should include blood pressure, growth parameters, presence of rashes, edema, and in the newborn, palpation of the kidneys.<sup>6</sup> A child with symptoms or an abnormal physical exam should have further evaluation of the abnormalities to investigate a possible association with the proteinuria. When proteinuria is associated with either symptoms or an abnormal physical exam it is called non-isolated proteinuria. In many children, the history and physical exam will be completely normal. In this case, the proteinuria is termed isolated or asymptomatic proteinuria.

Some of the most common causes of asymptomatic proteinuria in an otherwise healthy child are listed in Table 4.<sup>11</sup> In the child less than six years of age, idiopathic nephrotic syndrome is the most frequent diagnosis. The most common cause in the older child is postural or orthostatic proteinuria. Orthostatic proteinuria is generally considered a benign protein excretion in abnormal quantities when a patient is upright and active, but normal urinary protein excretion after a patient has been recumbent for several hours. In order to confirm this diagnosis, one must perform the orthostatic test.<sup>11</sup> The patient should be instructed to urinate just before retiring to bed and discard this urine. The patient must remain supine all night and immediately upon arising in the morning should urinate and label this sample as a "supine urine sample." Another urine sample is collected after normal daily activity and should be labeled "active urine sample." When these samples are assessed, the supine sample should be free of protein and the active urine will have protein present if the diagnosis is orthostatic proteinuria. Finding protein present in the supine sample rules out a diagnosis of orthostatic proteinuria.

Orthostatic proteinuria is rare in the child under six years of age. Between the ages of one and six years, subclinical

idiopathic nephrotic syndrome is the most common cause of proteinuria.<sup>11</sup> It is manifest by proteinuria without hematuria, hypoproteinemia and hypercholesterolemia. These findings can precede the clinical finding of edema by several weeks. Post-infectious glomerulonephritis, membranoproliferative glomerulonephritis, membranous glomerulonephritis, and focal segmental glomerulosclerosis can also present with isolated proteinuria, but often have hematuria as well. Patients with post-infectious and membranoproliferative glomerulonephritis usually also have low  $C_3$  levels, compared to a normal  $C_3$  in patients with membranous glomerulonephritis and focal segmental glomerulosclerosis. Chronic pyelonephritis and congenital anomalies such as renal hypoplasia and polycystic kidney disease also may present with isolated proteinuria and can usually be diagnosed by VCUG and/or renal ultrasound.

**Table 4.**  
**Causes of Asymptomatic Proteinuria**

- \* Orthostatic Proteinuria
- \* Idiopathic Nephrotic Syndrome
- \* Post-infectious Glomerulonephritis
- \* Membranoproliferative Glomerulonephritis
- \* Membranous Glomerulonephritis
- \* Focal Segmental Glomerulosclerosis
- \* Chronic Pyelonephritis
- \* Polycystic Kidney Disease
- \* Renal Hypoplasia

An algorithm outlining a work up for a child with isolated proteinuria is shown in Figure 1.<sup>11</sup> Finding at least two out of three urines positive for protein warrants a work-up which should include electrolytes, BUN, serum creatinine, albumin, total protein and  $C_3$ . Microscopic examination of urine should be done looking for casts, erythrocytes for leukocytes, and urine culture should be obtained. A 24 hour urine collection is essential to quantify daily protein excretion and assess creatinine clearance, as a measure of glomerular filtration rate (GFR).

If all the laboratory work is normal except for protein excretion, and the child is more than six years of age, then the orthostatic test should be done. If this is diagnostic, yearly follow up should be adequate. If findings of the orthostatic test are not consistent with orthostatic proteinuria or if the child is less than six years of age, radiographic studies and possible renal biopsy are indicated.

Abnormal laboratory always warrants further work up. Low GFR necessitates obtaining radiographic studies and renal biopsy. Presence of hematuria with proteinuria or a low  $C_3$  is likely to be due to a glomerulonephritis and biopsy is usually indicated unless post-streptococcal glomeruloneph-



ritis can be diagnosed. Hypoproteinemia and hypercholesterolemia point to a diagnosis of idiopathic nephrotic syndrome if a child is one to six years of age. If this child is treated with corticosteroids and responds, close follow up is adequate. Failure to respond to this treatment requires a renal biopsy. Children less than one year of age or more than six years of age who are not in the diagnostic age group also need a renal biopsy for definitive diagnosis.

Knowing the quantity of protein excreted in urine in 24 hours remains important in terms of evaluating degree of proteinuria, monitoring disease progress, and following success of treatment. Unfortunately, obtaining a 24 hour urine collection is often inconvenient and in a very young infant, nearly impossible without using a foley catheter. For these reasons attempts have been made to find another equally effective way of assessing protein excretion, and this has been the use of a random urine sample for calculation of the protein to creatinine ratio.

Urinary creatinine excretion is generally stable in a given patient during a day. Since protein excretion is also stable in a given patient over a day's time, then a simple ratio of ratio of urinary protein to urinary creatinine from a single voided urine should re-

reflect the cumulative protein excretion during a day as the ratio of two stable rates cancels out the time factor.<sup>12</sup> This has actually been suggested to be more accurate than a 24 hour urine because it avoids collection errors.

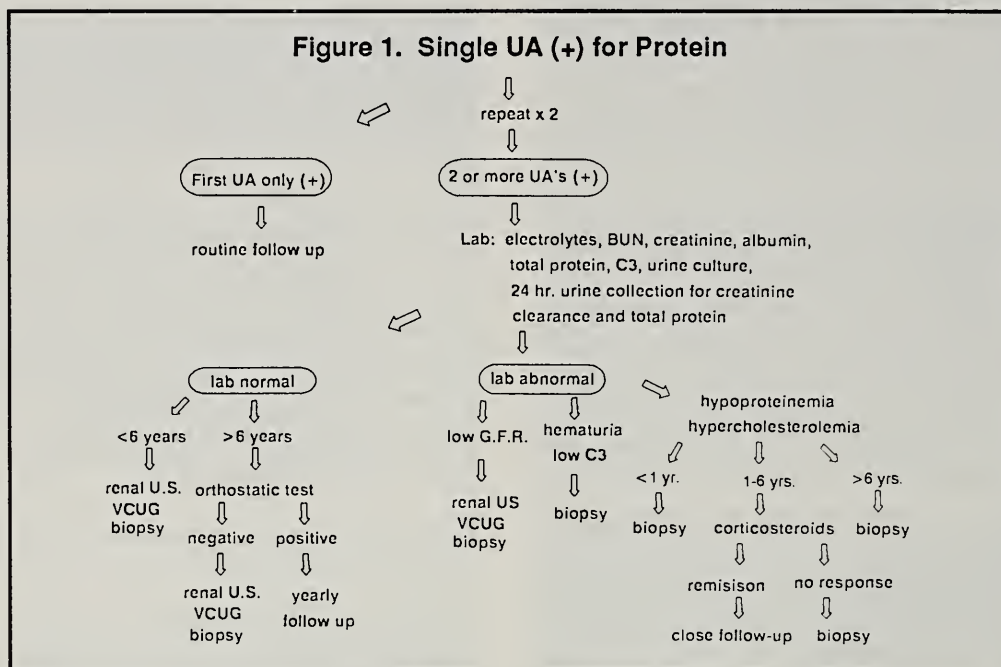
Several studies have been done looking at this using various methods of protein analysis, and in different age groups. Ginsberg and co-workers<sup>12</sup> in 1983 studied 46 adult patients ages 13-76 years with 24 hour urine collections in comparison with a random urine sample (Table 8). All patients who excreted greater than 3.5g/1.73m<sup>2</sup>/24hrs had a protein/creatinine ratio of greater than 3.5 in a single voided urine, and patients with less than 0.2g/1.73m<sup>2</sup>/24hrs had urine protein/creatinine ratios of less than 0.2. Five patients had a high urine protein/creatinine ratio from the random sample, but total urine protein in the 24 hour collection was less than what would be expected. Further questioning of these patients gave evidence that 4/5 had incorrectly collected their 24 hour urines. This provides an even stronger

argument that using protein/creatinine ratio may be more accurate than 24 hour collections. Houser<sup>13</sup> and Abitol<sup>14</sup> investigated the relationship of urine protein/urine creatinine in pediatric patients. They also found a correlation between daily protein excretion from the 24 hour urine collection and urine protein/creatinine ratio from a random sample. One disadvantage of using the random urine protein/creatinine ratio is that one must consider the rate of creatinine excretion in the individual. Since creatinine excretion varies according to one's nutritional status and muscle mass, this could interfere with the protein/creatinine ratio if a patient were either extremely muscular or wasted.

In conclusion, proteinuria is defined differently for various age groups based on differences in body surface area and normal renal function. The normal processes of glomerular filtration and tubular reabsorption may be altered leading to

abnormal protein excretion. It may be concluded from studies done to date that proteinuria is a common occurrence in children, but fortunately it is not commonly associated with underlying renal disease. Identifying those few children who do have renal dysfunction is important, however, a child who has persistent proteinuria should have a

Figure 1. Single UA (+) for Protein



detailed history, physical exam and laboratory evaluation. Pending those results, radiographic studies and/or renal biopsy may also be required. Studies are currently investigating the use of a protein to creatinine ratio from a random urine sample as an alternative to a 24 hour urine collection as a means of assessing proteinuria.

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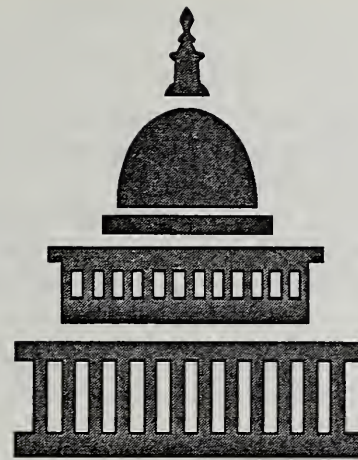
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# How to Unveil Legislative Initiative

Harold L. Jensen, M.D.\*



*This article originally appeared in the June 7, 1991 issue of Chicago Medicine and is reprinted with permission from the Chicago Medical Society. The recommendations for political involvement suggested by Dr. Jensen would serve as an excellent example for Arkansas physicians.*

**T**he most common expression of any I hear in the physicians' lounge is, "Why doesn't somebody do something about...." The complainer then completes the sentence with his favorite gripe. But for physicians, our most serious problems of payment, patient access, and regulation are born in the legislature. Someone *can* do something about that. You can.

## Take the Initiative

Whether growing roses, raising children, or learning new skills, patience and persistence are required. Likewise, they are the key ingredients needed to develop a relationship with your legislator. These relationships will have a much greater impact if a personal rapport exists between you and your legislator.

Most legislators want to know their constituents, but don't expect them to take the initiative to meet with you. Instead, physicians should try to make friends with their legislators. Effective influence comes in the form of constituent-based support and grass-roots activity. This is where physicians, individually and collectively, through hospital medical staffs and county societies, must have a direct role in the political process.

Take advantage of opportunities within the district to meet your legislator, or create opportunities on your own. There are any number of ways to meet your legislator: over lunch, in civic groups, at a fund-raiser or benefit, in the office, and so forth. You can create the opportunity by

inviting your legislator to your office or to your hospital to address colleagues. Physicians should use their hospitals to reach out to legislators. Hospitals are large employers and legislators want to spend their time with more than a few voters. This setting allows legislators the opportunity to make multiple contacts, to be seen in the district, and possibly to receive some press coverage. A hospital visit enables the legislator to see physicians in the physicians' environment. Physicians should be aware of these facts and make a legislator's visit worthwhile for both organized medicine and the legislator.

## Be Patient, Preserverant

These relationships should be developed primarily at a time when you are not attempting to lobby an issue. Once you do have an issue or problem, a previously established relationship will open the door. Understanding and an exchange of information with your legislator will be based on trust and confidence. The confidant will be more trusted than a newcomer who brings a questionable argument to the legislator.

When making personal contacts, it may be difficult to coordinate both of your busy schedules. Remember, patience and perseverance are essential. Unless you already know your legislator well, you should write to request a meeting or schedule an appointment. Legislators often respond better to groups to make effective use of their time. Perhaps at your next medical staff meeting, you could discuss the possibilities of a group meeting or trip to the legislator's district office. Whether you communicate with your legislator by phone, letter, or in person, you should be concise, positive, and constructive. Preparation and factual information will facilitate an on-going relationship, increase your credibility, and ensure trust.

## Get the Facts

To maximize your contact, get the facts on your legislator first. Find out as much as you can about your elected officials. Background information on these individuals is

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\* Dr. Jensen is past president of the Chicago Medical Society.



available through their district offices, your county and state medical societies, the Illinois State Medical Society governmental affairs division, and the governmental affairs council. Another excellent source for background information is the "Almanac of Illinois Politics," published by *Illinois Issues* of Sangamon State University.

Once you are familiar with your legislator, stay informed and involved. Know the key committees on which he serves. What is his voting record? From where does his support come? What is his stand on key issues?

Also, volunteer to serve on a campaign committee or walk precincts during election day to get out the vote for your elected officials; legislators respond to people who help them. Keep in mind that your goal is to develop a relationship with your legislator to effectively express your legislative concerns. You should voice your opinion to your legislator or to his staff when you are pleased with a position taken. Legislators will respond more to those constituents who not only call to complain but also to compliment as well.

Legislators will soon redraw the political boundaries to determine control of state legislatures nationwide. This redistricting will determine what happens to health-care issues and legislation during this decade. Organized medicine faces formidable challenges from special-interest foes who stand to gain increased power through the redistricting process.

Some changes are inevitable, but we can practice preventive medicine and stem major challenges by firmly supporting those legislators who understand our profession and by strengthening our relationships with those who are willing to listen to our views.

### **It Makes A Difference**

Involvement in the political process has become an integral part of our profession. Making the most of personal contacts with your legislator will enhance you personally and professionally. You need to take this message back to your colleagues and work to increase their participation in our political process. Physician involvement does make a difference.

When the legislators or their staff begin to ask you for advice and turn to your expertise before casting their votes on medical issues, a successful, productive relationship is established. It's a two-way street.

Not only will they benefit from your valuable input on health-care issues, but also organized medicine will benefit from legislators' better understanding of our profession.

When you next hear "Why doesn't somebody *do* something about the legislature?" I hope this article provides you with an answer. If you have an answer to this question—"Why don't they do something about lawyers?"—call me, collect. ■

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**"Legislators will respond more to those constituents who not only call to complain but also to compliment as well."**

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## Recommendations for Preventing Transmission of HIV and HBV to Patients During Exposure-Prone Invasive Procedures

*This document has been developed by the Centers for Disease Control (CDC) to update recommendations for prevention of transmission of human immunodeficiency virus (HIV) and hepatitis B virus (HBV) in the health-care setting. Current data suggest that the risk for such transmission from a health-care worker (HCW) to a patient during an invasive procedure is small; a precise assessment of the risk is not yet available. This document contains recommendations to provide guidance for prevention of HIV and HBV transmission during those invasive procedures that are considered exposure-prone.*

**R**ecommendations have been made by the Centers for Disease Control (CDC) for the prevention of transmission of the human immunodeficiency virus (HIV) and hepatitis B (HBV) in health-care settings.<sup>1-6</sup> These recommendations emphasize adherence to universal precautions that require that blood and other specified body fluids of all patients be handled as if they contain blood-borne pathogens.<sup>1,2</sup>

Previous guidelines contained precautions to be used during invasive procedures (defined in Appendix) and recommendations for the management of HIV- and HBV-infected health-care workers (HCWs).<sup>1</sup> These guidelines did not include specific recommendations on testing HCWs for HIV or HBV infection, and they did not provide guidance on which invasive procedures may represent increased risk to the patient.

The recommendations outlined in this document are based on the following considerations:

- ☐ Infected HCWs who adhere to universal precautions and who do not perform invasive procedures pose no risk for transmitting HIV or HBV to patients.
- ☐ Infected HCWs who adhere to universal precautions and who perform certain exposure-prone procedures pose a small risk for transmitting HBV to patients.
- ☐ HIV is transmitted much less readily than HBV.

In the interim, until further data are available, additional precautions are prudent to prevent HIV and HBV transmission during procedures that have been linked to HCW-to-patient HBV transmission or that are considered exposure-prone

### Background

#### *Infection-Control Practices*

Previous recommendations have specified that infection-control programs should incorporate principles of universal precautions (i.e., appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments) and should maintain these precautions rigorously in all health-care settings.<sup>1,2,5</sup> Proper application of these principles will assist in minimizing the risk of transmission of HIV or HBV from patient to HCW, HCW to patient, or patient to patient.

As part of standard infection-control practice, instruments and other reusable equipment used in performing invasive procedures should be appropriately disinfected and sterilized as follows:<sup>7</sup>

- ☐ Equipment and devices that enter the patient's vascular

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Reprinted from: Centers for Disease Control. Recommendation for prevention of HIV transmission in health-care settings. MMWR 1987; 36 (suppl. no 2S):6S-7S.



system or other normally sterile areas of the body should be sterilized before being used for each patient.

- ❑ Equipment and devices that touch intact mucous membranes but do not penetrate the patient's body surfaces should be sterilized when possible or undergo high-level disinfection if they cannot be sterilized before being used for each patient.
- ❑ Equipment and devices that do not touch the patient or that only touch intact skin of the patient need only be cleaned with a detergent or as indicated by the manufacturer.

Compliance with universal precautions and recommendations for disinfection and sterilization of medical devices should be scrupulously monitored in all health-care settings.<sup>1,7,8</sup> Training of HCWs in proper infection-control technique should begin in professional and vocational schools and continue as an ongoing process. Institutions should provide all HCWs with appropriate inservice education regarding infection control and safety and should establish procedures for monitoring compliance with infection-control policies.

All HCWs who might be exposed to blood in an occupational setting should receive hepatitis B vaccine, preferably during their period of professional training and before any occupational exposures could occur.<sup>8,9</sup>

#### *Transmission of HBV During Invasive Procedures*

Since the introduction of serologic testing for HBV infection in the early 1970s, there have been published reports of 20 clusters in which a total of over 300 patients were infected with HBV in association with treatment by an HBV-infected HCW. In 12 of these clusters, the implicated HCW did not routinely wear gloves; several HCWs also had skin lesions that may have facilitated HBV transmission.<sup>10-22</sup> These 12 clusters included nine linked to dentists or oral surgeons and one cluster each linked to a general practitioner, an inhalation therapist, and a cardiopulmonary-bypass-pump technician. The clusters associated with the inhalation therapist and the cardiopulmonary-bypass-pump technician - and some of the other 10 clusters - could possibly have been prevented if current recommendations on universal precautions, including glove use, had been in effect. In the remaining eight clusters, transmission occurred despite glove use by the HCWs; five clusters were linked to obstetricians or gynecologists, and three were linked to cardiovascular surgeons.<sup>6,22-28</sup> In addition, recent unpublished reports strongly suggest HBV transmission from three surgeons to patients in 1989 and 1990 during colorectal (CDC, unpublished data), abdominal, and cardiothoracic surgery.<sup>29</sup>

Seven of the HCWs who were linked to published clusters in the United States were allowed to perform invasive procedures following modification of invasive techniques (e.g., double gloving and restriction of certain high-risk procedures).<sup>6,11-13,15,16,24</sup> For five HCWs, no further transmission to patients was observed. In two instances

involving an obstetrician/gynecologist and an oral surgeon, HBV was transmitted to patients after techniques were modified.<sup>6,12</sup>

Review of the 20 published studies indicates that a combination of risk factors accounted for transmission of HBV from HCWs to patients. Of the HCWs whose hepatitis B e antigen (HBeAg) status was determined (17 of 20), all were HBeAg positive. The presence of HBeAg in serum is associated with higher levels of circulating virus and therefore with greater infectivity of hepatitis-B-surface-antigen (HBsAg)-positive individuals; the risk of HBV transmission to an HCW after a percutaneous exposure to HBeAg-positive blood is approximately 30%.<sup>30-32</sup> In addition, each report indicated that the potential existed for contamination of surgical wounds or traumatized tissue, either from a major break in standard infection-control practices (e.g., not wearing gloves during invasive procedures) or from unintentional injury to the infected HCW during invasive procedures (e.g., needle sticks incurred while manipulating needles without being able to see them during suturing.)

Most reported clusters in the United States occurred before awareness increased of the risks of transmission of blood-borne pathogens in health-care settings and before emphasis was placed on the use of universal precautions and hepatitis B vaccine among HCWs. The limited number of reports of HBV transmission from HCWs to patients in recent years may reflect the adoption of universal precautions and increased use of HBV vaccine. However, the limited number of recent reports does not preclude the occurrence of undetected or unreported small clusters or individual instances of transmission; routine use of gloves does not prevent most injuries caused by sharp instruments and does not eliminate the potential for exposure of a patient to an HCW's blood and transmission of HBV.<sup>6,22-29</sup>

#### *Transmission of HIV During Invasive Procedures*

The risk of HIV transmission to an HCW after percutaneous exposure to HIV infected blood is considerably lower than the risk of HBV transmission after percutaneous exposure to HBeAg-positive blood (0.3% versus approximately 30%).<sup>33-35</sup> Thus, the risk of transmission of HIV from an infected HCW to a patient during an invasive procedure is likely to be proportionately lower than the risk of HBV transmission from an HBeAg-positive HCW to a patient during the same procedure. As with HBV, the relative infectivity of HIV probably varies among individuals and over time for a single individual. Unlike HBV infection, however, there is currently no readily available laboratory test for increased HIV infectivity.

Investigation of a cluster of HIV infections among patients in the practice of one dentist with acquired immunodeficiency syndrome (AIDS) strongly suggested that HIV was transmitted to five of the approximately 850 patients evaluated through June 1991.<sup>36-38</sup> The investigation indicates that HIV transmission occurred during dental care, although the precise mechanisms of transmission have not



been determined. In two other studies, when patients cared for by a general surgeon and a surgical resident who had AIDS were tested, all patients tested, 75 and 62, respectively, were negative for HIV infection.<sup>39,40</sup> In a fourth study, 143 patients who had been treated by a dental student with HIV infection and were later tested were all negative for HIV infection.<sup>41</sup> In another investigation, HIV antibody testing was offered to all patients whose surgical procedures had been performed by a general surgeon within seven years before the surgeon's diagnosis of AIDS; the date at which the surgeon became infected with HIV is unknown.<sup>42</sup> Of 1,340 surgical patients contacted, 616 (46%) were tested for HIV. One patient, a known intravenous drug user, was HIV positive when tested but may already have been infected at the time of surgery. HIV test results for the 615 other surgical patients were negative (95% confidence interval for risk of transmission per operation = 0.0%-0.5%).

The limited number of participants and the differences in procedures associated with these five investigations limit the ability to generalize from them and to define precisely the risk of HIV transmission from HIV-infected HCWs to patients. A precise estimate of the risk of HIV transmission from HIV-infected HCWs to patients can be determined only after careful evaluation of a substantially larger number of patients whose exposure-prone procedures have been performed by HIV-infected HCWs.

### *Exposure-Prone Procedures*

Despite adherence to the principles of universal precautions, certain invasive surgical and dental procedures have been implicated in the transmission of HBV from infected HCWs to patients, and should be considered exposure-prone. Reported examples include certain oral, cardiothoracic, colorectal (CDC, unpublished data), and obstetric/gynecologic procedures.<sup>6,12,22-29</sup>

Certain other invasive procedures should also be considered exposure-prone. In a prospective study CDC conducted in four hospitals, one or more percutaneous injuries occurred among surgical personnel during 96 (6.9%) of 1,382 operative procedures on the general surgery, gynecology, orthopedic, cardiac, and trauma services.<sup>43</sup> Percutaneous exposure of the patient to the HCW's blood may have occurred when the sharp object causing the injury recontacted the patient's open wound in 28 (32%) of the 88 observed injuries to surgeons (range among surgical specialties = 8%-57%; range among hospitals = 24%-42%).

**Characteristics of exposure-prone procedures include digital palpation of a needle tip in a body cavity or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site. Performance of exposure-prone procedures presents a recognized risk of percutaneous injury to the HCW, and - if such an injury occurs - the HCW's blood is likely to**

**contact the patient's body cavity, subcutaneous tissues, and/or mucous membranes.**

Experience with HBV indicates that invasive procedures that do not have the above characteristics would be expected to pose substantially lower risk, if any, of transmission of HIV and other blood-borne pathogens from an infected HCW to patients.

### **Recommendations**

Investigations of HIV and HBV transmission from HCWs to patients indicate that, when HCWs adhere to recommended infection-control procedures, the risk of transmitting HBV from an infected HCW to a patient is small, and the risk of transmitting HIV is likely to be even smaller. However, the likelihood of exposure of the patient to an HCW's blood is greater for certain procedures designated as exposure-prone. To minimize the risk of HIV or HBV transmission, the following measures are recommended:

- ☐ All HCWs should adhere to universal precautions, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments. HCWs who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment and devices used in performing invasive procedures until the condition resolves. HCWs should also comply with current guidelines for disinfection and sterilization of reusable devices used in invasive procedures.
- ☐ Currently available data provide no basis for recommendations to restrict the practice of HCWs infected with HIV or HBV who perform invasive procedures not identified as exposure-prone, provided the infected HCWs practice recommended surgical or dental technique and comply with universal precautions and current recommendations for sterilization/disinfection.
- ☐ Exposure-prone procedures should be identified by medical/surgical/dental organizations and institutions at which the procedures are performed.
- ☐ HCWs who perform exposure-prone procedures should know their HIV anti-body status. HCWs who perform exposure-prone procedures and who do not have serologic evidence of immunity to HBV from vaccination or from previous infection should know their HBsAg status and, if that is positive, should also know their HBeAg status.
- ☐ HCWs who are infected with HIV or HBV (and are HBeAg positive) should not perform exposure-prone procedures unless they have sought counsel from an expert review panel and been advised under what cir-



cumstances, if any, they may continue to perform these procedures.\* Such circumstances would include notifying prospective patients of the HCW's seropositivity before they undergo exposure-prone invasive procedures.

Mandatory testing of HCWs for HIV antibody, HBsAg, or HBeAg is not recommended. The current assessment of the risk that infected HCWs will transmit HIV or HBV to patients during exposure-prone procedures does not support the diversion of resources that would be required to implement mandatory testing programs. Compliance by HCWs with recommendations can be increased through education, training, and appropriate confidentiality safeguards.

## HCWs Whose Practices are Modified Because of HIV or HBV Status

HCWs whose practices are modified because of their HIV or HBV infection status should, whenever possible, be provided opportunities to continue appropriate patient-care activities. Career counseling and job retraining should be encouraged to promote the continued use of the HCW's talents, knowledge and skills. HCWs whose practices are modified because of HBV infection should be re-evaluated periodically to determine whether their HBeAg status changes due to resolution of infection or as a result of treatment.<sup>44</sup>

## Notification of Patients and Follow-up Studies

The public health benefit of notification of patients who have had exposure-prone procedures performed by HCWs infected with HIV or positive for HBeAg should be considered on a case-by-case basis, taking into consideration an assessment of specific risks, confidentiality issues, and available resources. Carefully designed and implemented follow-up studies are necessary to determine more precisely the risk of transmission during such procedures. Decisions regarding notification and follow-up studies should be made in consultation with state and local public health officials.

## Additional Needs

- ☐ Clearer definition of the nature, frequency, and circumstances of blood contact between patients and HCWs during invasive procedures.
- ☐ Development and evaluation of new devices, protective barriers, and techniques that may prevent such blood contact without adversely affecting the quality of patient care.
- ☐ More information on the potential for HIV and HBV transmission through contaminated instruments.
- ☐ Improvements in sterilization and disinfection techniques for certain reusable equipment and devices.
- ☐ Identification of factors that may influence the likelihood of HIV or HBV transmission after exposure to HIV- or HBV-infected blood.

## References

1. CDC. Recommendations for prevention of HIV transmission in health-care settings. *MMWR* 1987; 36(suppl. no 2S):1-18S.
2. CDC. Update: Universal precautions for prevention of transmission of human immunodeficiency virus, hepatitis B virus, and other bloodborne pathogens in health-care settings. *MMWR* 1988; 37:377-82, 387-8.
3. CDC. Hepatitis Surveillance Report No. 48. Atlanta: U.S. Department of Health and Human Services, Public Health Service, 1982:2-3.
4. CDC. CDC Guideline for Infection Control in Hospital Personnel, Atlanta, Georgia: Public Health Service, 1983. 24 pages. (GPO# 6AR031488305).
5. CDC. Guidelines for prevention of transmission of human immunodeficiency virus and hepatitis B virus to health-care and public-safety workers. *MMWR* 1989; 38 (suppl. no s-6):1-37.
6. Lettau LA, Smith JD, Williams D, et al. Transmission of hepatitis B with resultant restriction of surgical practice. *JAMA* 1986; 255:934-7.
7. CDC. Guidelines for the prevention and control of nosocomial infections: guideline for hand washing and hospital environment control. Atlanta, Georgia: Public Health Service, 1985. 20 pages. (GPO# 544-436/24441).
8. Department of Labor, Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens: proposed rule and notice of hearing. *Federal Register* 1989; 54:23042-139.
9. CDC. Protection against viral hepatitis: recommendations of the immunization practices advisory committee (ACIP). *MMWR* 1990; 39:(no, RR-2).
10. Levin ML, Maddrey WC, Wands JR, Mendeloff Al. Hepatitis B transmission by dentists. *JAMA* 1974; 228:1139-40.

For a complete list of references, please contact the AMS Society office.

\* The review panel should include experts who represent a balanced perspective. Such experts might include all of the following: a) the HCW's personal physician(s), b) an infectious disease specialist with expertise in the epidemiology of HIV and HBV transmission, c) a health professional with expertise in the procedures performed by the HCW, and d) state or local public health official(s). If the HCW's practice is institutionally based, the expert review panel might also include a member of the infection-control committee, preferably a hospital epidemiologist. HCWs who perform exposure-prone procedures outside the hospital/institutional setting should seek advice from appropriate state and local public health officials regarding the review process. Panels must recognize the importance of confidentiality and the privacy rights of infected HCWs.

## Appendix

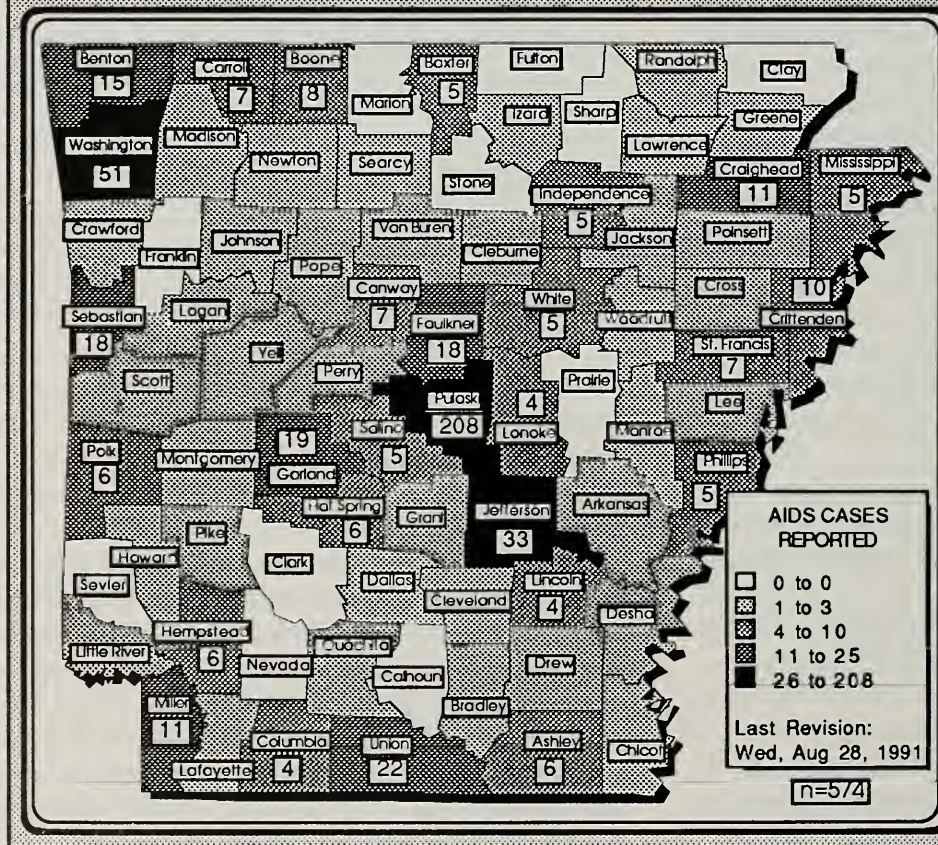
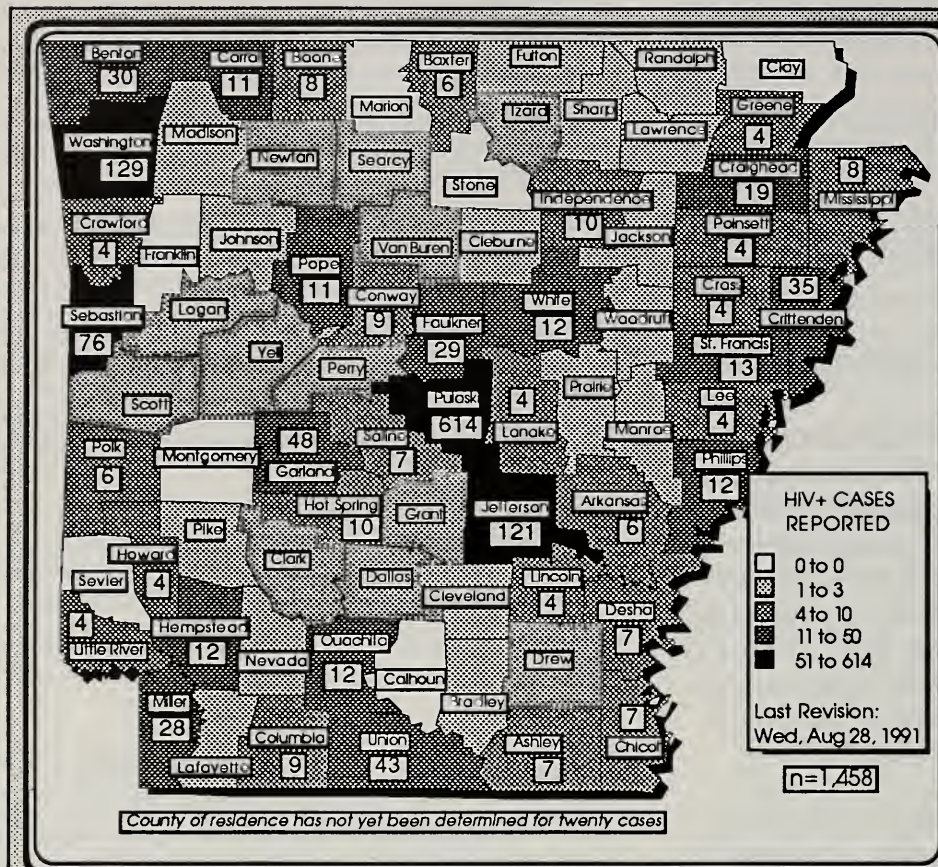
### Definition of Invasive Procedure

An invasive procedure is defined as "surgical entry into tissues, cavities, or organs or repair of major traumatic injuries" associated with any of the following: "1) an operating or delivery room, emergency department, or out-patient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists." ■



# Arkansas HIV/AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

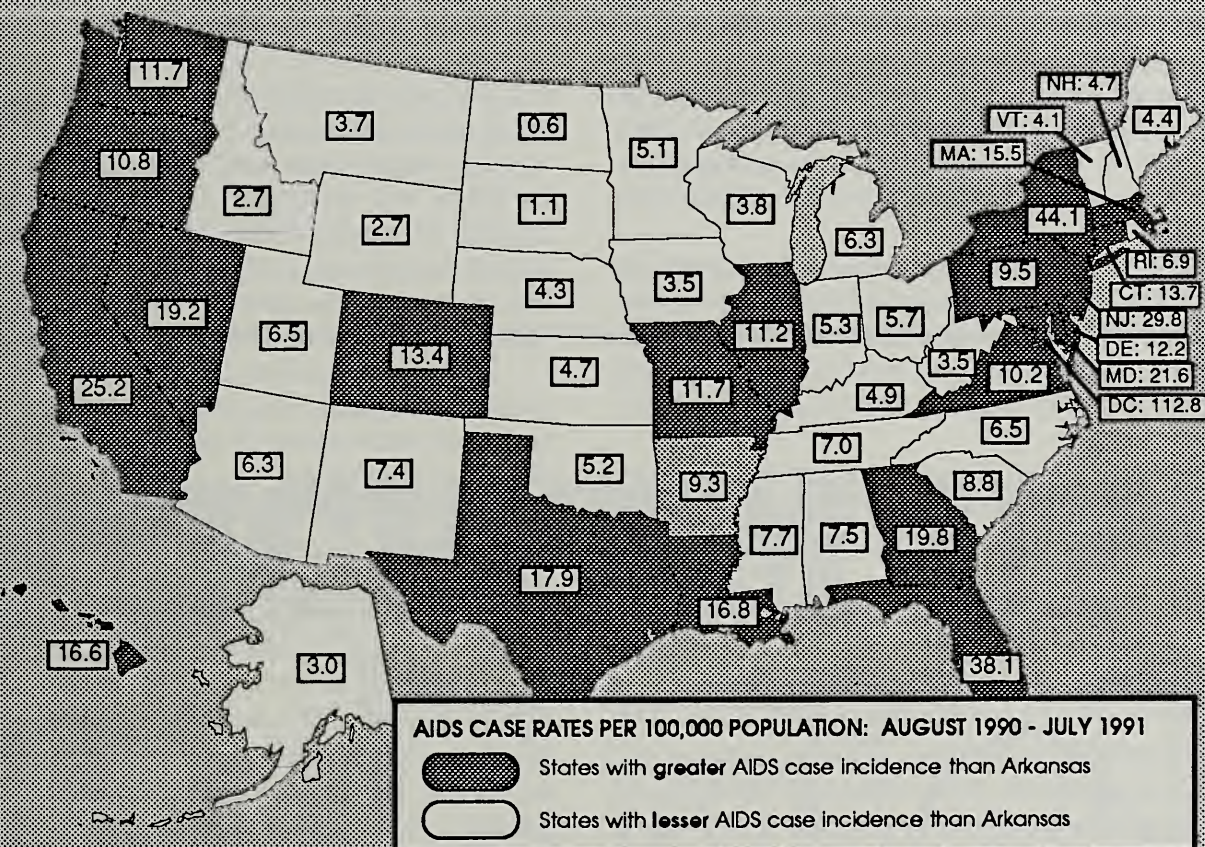
Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# Arkansas AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: AUG '90 - JULY '91	219	Reported: AUG '90 - JULY '91	43,580
Rates per 100,000 population: AUG '90 - JULY '91	9.3	Rates per 100,000 population: AUG '90 - JULY '91	17.1
Cumulative Reports: 1983 - AUG '91	574	Cumulative Reports: 1980 - JUL '91	186,895
Adult	560	Adult	183,696
Pediatric	14	Pediatric	3,199
Deaths: 1983 - AUG '91	318	Deaths: 1980 - JUL '91	118,411
Adult	312	Adult	116,734
Pediatric	6	Pediatric	1,677
Mortality Rate	55.4%	Mortality Rate	63.4%



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	62.0%	Gay or Bisexual Men	57.8%
Heterosexual IV Drug Users	11.7%	Heterosexual IV Drug Users	21.8%
Gay or Bisexual Men who used IV Drugs	9.6%	Gay or Bisexual Men who used IV Drugs	6.5%
Heterosexual contact with person at risk	5.2%	Heterosexual contact with person at risk	5.5%
Transfusion with blood products	4.4%	Transfusion with blood products	2.3%
Perinatal	1.9%	Perinatal	1.4%
Hemophilia	1.9%	Hemophilia	0.9%
Risk unknown at this time	3.3%	Risk unknown at this time	3.7%



## A Missed Opportunity?

J. Kelley Avery, M.D.\*

A 29 year old truck driver sustained a lifting injury to his back while unloading freight in December of 1984. Five days after the injury, he reported to his primary care physician with pain in his low back with some radiation into the right leg.

Physical examination revealed only a 3+ straight-leg raising test on the right and significant limitation of motion in the low back. The patient was treated with bed rest, heat, and analgesics, and after no improvement in 10 days was referred to an orthopedic surgeon for evaluation and treatment.

Two more weeks of conservation therapy followed, including some effort at mobilization with passive exercises, heat, analgesics, and rest on a hard bed. Again, there was no response.

In March, some three months after the initial injury, the physical examination again revealed limitation of motion in the back, positive straight leg raising on the right, but there were no objective findings of motor or sensory deficit. The DTR were recorded as being "okay." Routine x-rays of the back showed no significant abnormality. A CT and myelogram showed an extradural defect on the right involving the L 4-5 space.

Chemoneucleolysis followed, and after what appeared to be some initial improvement, the patient continued to complain of pain, required analgesics, and was unable to return to work.

In September of the same year, a repeat CT and myelogram again revealed the right extradural defect at level of L

4-5. The record indicated that conservative therapy had failed, and a lumbar discectomy was scheduled.

The surgery was done on the left side due to some confusion that developed in the pre-op preparation and draping. The operative note indicated that disk material was located centrally and on the right and was removed. Following the surgery, the patient was fully informed as to the operative approach from the left side instead of the right.

Again there was little or no relief. Pain persisted all the while and analgesics were required. Attempts at physiotherapy failed, and a repeat CT again revealed the central bulge at the L 4-5 interspace.

The patient failed to keep a scheduled appointment with his orthopaedic surgeon, and in December of the same year was re-operated by another surgeon. Shortly after that operation was done, a lawsuit was filed. Expert witnesses for the defendant doctor and the patient were both deposed. The initial operating surgeon and experts for the defense all testified that although it was a deviation from an acceptable standard of care to approach a right extradural defect from the left, it can be done, and sometimes herniated disk material can be satisfactorily removed. The operating surgeon felt that all of the significant disk material had been removed at the initial operation, and his experts testified that this was certainly possible. However, expert witnesses for the patient contended that it was indeed a departure from an acceptable standard to approach a lumbar discectomy from the wrong side and that, therefore, results could be expected to be less than optimum.

There was substantial question that the CT preoperatively was significantly different from the post-op CT. Recovery was slow, and a significant disability resulted.

The extent of psychosomatic overlay was difficult, if not impossible, to assess. A substantial settlement was necessary to avoid a jury trial.

---

\* Dr. Avery is chairman of the Loss Prevention Committee at State Volunteer Mutual Insurance Company in Brentwood, Tennessee and medical director of Ambulatory Services at St. Thomas Hospital in Nashville, Tennessee.



## Comments

Workers Compensation back injuries are known to be very difficult cases. Both the employer and the employee have a vested interest in prompt and aggressive management of the complaint. The worker needs to get back to work, and the employer needs an able worker. With this kind of pressure on the physician to "fix it," it is almost impossible to remain totally objective in the evaluation and approach to treatment.

In this case, while there was no evidence of mismanagement in the initial approach to treatment (chemonucleolysis), one wonders about the three months' delay between the initial injury and definitive treatment without any record of vigorous physical and occupational therapy. Additionally, there was no record of an objective neurological evaluation. There was, however, in more than one location in the record, the note that reflexes were "equal and 2+," and that there was "no evidence of motor or sensory deficit."

There is no record of any involvement of the employer in a "early return to work attempt." In fact, following the chemonucleolysis, there was little in the way of systematic physical therapy. This may have been the time when a thoughtful application of what we know about physical/occupational therapy could have prevented further surgery.

Apart from heat, a hard bed, and analgesics, little was done to encourage rehabilitation. Even though approaching a right L 4-5 extradural defect from the left was considered negligence and significant settlement resulted, one must wonder how differently this case would have turned out if, from the very beginning, aggressive use of modern occupational/physical therapy had been employed. This kind of approach involves the best efforts of employers, physicians, physical therapists, and patients.

Confusion between left and right is a very frequent occurrence in the practice of medicine. Usually the confusion is clarified before an invasive procedure is done. However, when the confusion leads to surgery on the wrong side, as it did here, we pay!! In the checklist completed pre-operatively, the surgeon should be asked to confirm the correct side of the abnormality.

Neurosurgeons and orthopedics surgeons, who generally manage these cases, definitively pay very high malpractice insurance premiums. The Workers Compensation back injury is a fairly frequent cause of malpractice litigation, and the losses in this area are considerable. Perhaps the early and aggressive approach to rehabilitation employing all modalities at our command could result in a reduction in the risk to all concerned.

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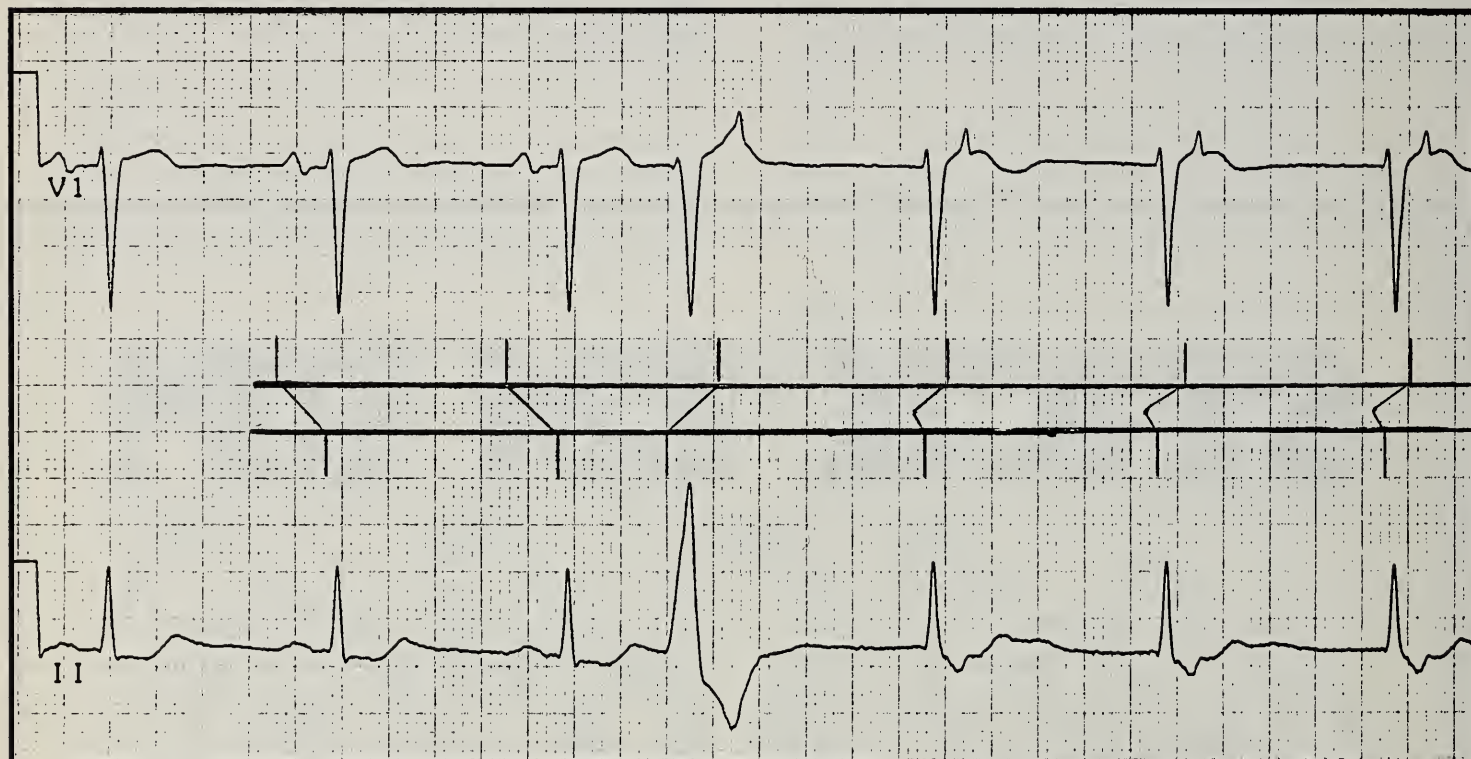


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## CLINICAL HISTORY:

This record was obtained from a 54 year-old male with a history of end stage renal disease being treated with chronic ambulatory peritoneal dialysis. His medications included: digoxin, 0.125 mg three times weekly; sustained release verapamil, 240 mg daily; metoclopramide, 5 mg daily; ranitidine, 150 mg daily, amitriptyline, 50 mg prn; as well as vitamins and antacids. What is the rhythm?



## DISCUSSION:

Two rhythms are present. The first three and the last two complexes represent sinus rhythm. There is a four beat run of an accelerated junctional rhythm, preceded and followed by ventricular premature complexes (VPC's).

The sinus rhythm is at a rate of 61 with a PR interval of 210 msec, which is slightly prolonged. The first VPC is conducted retrogradely to the atrium, resetting the SA node. This delay allows a junctional focus to escape at a rate identical to the sinus rate, simply because the junctional focus was depolarized by the retrograde impulse before the SA node was depolarized. Sinus rhythm resumes after a VPC, which resets the junctional focus, but fails to be conducted retrogradely to the atrium. Generally, slowing of AV conduction ( $PR > 200$  msec) and acceleration of subsidiary pacemakers (a junctional focus at a rate  $\geq$  to 60) is a hallmark of digitalis excess. The combination of digoxin and verapamil may result in slowing of AV conduction in the absence of digitalis intoxication.



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CONTACT: \_\_\_\_\_

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☐ We do not have a computer.

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# New Members

---

## BENTON COUNTY

**Donnell, Hugh G.**, Family Practice, Rogers. Born, January 31, 1963, Ft. Benning, GA. Medical education, UAMS, 1988. Internship/residency, AHEC, Fort Smith, 1991.

**Foster, Douglas C.**, General & Laparoscopic Surgery, Gravette. Born, April 5, 1949, El Dorado, KS. Medical education, College of Osteopathic Medicine Oklahoma State University, Tulsa, 1986. Internship, Richmond Heights General Hospital, Ohio, 1987. Residency, General Osteopathic Hospital, Harrisburg, PA, 1991. Board eligible.

## CLEBURNE COUNTY

**Lambert, James C.**, Family Medicine, Heber Springs. Born, July 7, 1961, Lewisberg, TN. Medical education, UAMS, 1988. Internship/residency, AHEC-Pine Bluff, 1991. Pending certification.

## CRAIGHEAD/POINSETT COUNTY

**Beck, M. Lowery**, Pediatrics, Jonesboro. Born, December 25, 1961, Pine Bluff. Medical education, UAMS, 1988. Internship/residency, Children's Mercy Hospital, Kansas City, MO, 1991. Board eligible.

**Brown, Dennis R.**, Internal Medicine, Jonesboro. Born, June 6, 1962, Searcy. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991.

**Dunn, Charles C.**, OB/GYN, Jonesboro. Born August 3, 1915, Kansas City, KS. Medical education, Medical College of Wisconsin, Milwaukee, 1982. Internship/residency, David Grant Medical Center, Travis Air Force Base, 1986. Practice experience, 5 years. Board certified.

**Ricca Gregory F.**, Neurosurgery, Jonesboro. Born, May 6, 1957, Glencove, NY. Medical education, East Tennessee State University, Johnson City, TN, 1985. Internship/residency, University of Tennessee, Memphis, 1991.

**Sifford, Mark D.**, Pulmonary Medicine, Jonesboro. Born, June 3, 1959, Norman, OK. Medical education, UAMS, 1986. Internship/residency, UAMS, 1991. Board eligible.

## POPE COUNTY

**Jones Jr., Charles W.**, Family Practice, Russellville. Born, December 19, 1952, Little Rock. Medical education, UAMS, 1984. Internship, University of Tennessee, Memphis, 1987. Board certified. Practice experience, 4 years.

## PULASKI COUNTY

**Cope, Michael G.**, OB/GYN, Little Rock. Born, May 3 1961, Tuscoloosa, AL. Medical school, University of Alabama School of Medicine, Birmingham, 1983. Internship/residency, University of Tennessee Regional Medical Center, Memphis, 1991. Board eligible.

**Davidson, Alice K.**, Medical Consultant, Little Rock. Born, February 26, 1948, Columbia, MO. Medical education, UAMS, 1976. Internship, UAMS, Veterans Administration Hospital, and St. Vincents Infirmary Medical Center, 1977. Practice experience, 14 years.

**Huggins, David P.**, Anesthesiology, Little Rock. Born, July 10, 1956, Cleveland, MS. Medical education, University of Mississippi, Jackson, 1981. Internship, 1984. Residency, Arkahsas Children's Hospital, Little Rock, 1991. Board certified.

**Klimberg, V. Suzanne**, Brest Oncology, Little Rock. Born, June 24, 1954, Fayetteville. Medical education, University of Florida, Gainesville, 1984. Internship/residency, University of Florida, Gainesville, 1988.

**Kozlowski, Karen J.**, OB/GYN, Little Rock. Born, November 21, 1953, Hudson, NY. Medical Education, UAMS, 1986. Internship/residency, UAMS, 1989. Practice experience, 1 year. Board elibible.

**Morris, Barbara K.**, Otolaryngology, Little Rock. Born May 4, 1952, Morgantown, WV. Medical education, UAMS, 1986. Internship/residency, UAMS, 1991. Board eligible.

**Rommel, Raymond R.**, Psychiatry, Little Rock. Born, July 22, 1956, Little Rock. Medical education, University of Texas Medical School, Houston, 1987. Internship, University of Texas Medical School, Houston, 1988. Residency, Harbor-UCLA Medical Center, Torrance, 1991. Board eligible.

**Rice, James C.**, Internal Medicine, Little Rock. Born, February 28, 1951, Little Rock. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991.

**Stern, Scott**, Otolaryngology, Little Rock. Born, September 24, 1959, Jackson, MS. Medical education, UAMS, 1984. Internship, UAMS, 1989. Residency, M.O. Anderson, Houston, TX, 1991. Board certified.

**Waner, Milton**, Otolaryngology, Little Rock. Born October 29, 1953, Johannesburg, South Africa. Medical education, University of Witwatersrand, Johannesburg, SA, 1977. Internship, Baragwanath Hospital, Johannesburg, SA, 1978. Residency, Johannesburg Hospital, 1980; University of Witwatersrand, Johannesburg, SA, 1984. Board certified.

**Williamson III, Arian**, Otolaryngology, Little Rock.



Born, August 8, 1958, Pine Bluff. Medical education, Tulane University School of Medicine, 1985. Internship/residency, Tulane University School of Medicine, 1991.

## **SALINE COUNTY**

**Martindale, Mark A.**, Internal Medicine/Pediatrics, Benton. Born November 29, 1960, Little Rock. Medical education, UAMS, 1987. Internship/residency, Consortium for Health Education and Children's Mercy Hospital, 1991. Board eligible.

## **WASHINGTON COUNTY**

**Burton, Anthony R.**, General Surgery, Fayetteville. Born September 14, 1953, Texarkana, TX. Medical education, UAMS, 1982. Internship/residency, Methodist Medical Center, Dallas, TX, 1987. Practice experience, 4 years. Board certified.

**Kraichoke, Saran**, Pathology, Fayetteville. Born February 7, 1957, Bangkok, Thailand. Medical education, University of Southern California, Los Angeles, 1984. Internship, 1985. Residency, 1989. Board certified.

## **WHITE COUNTY**

**Lefler, Stephen F.**, OB/GYN, Searcy. Born February 8, 1959, Morrilton. Medical education, UAMS, 1986. Internship, AHEC, Pine Bluff, 1987. Residency, UAMS, 1991. Board eligible.

**Millstein, David I.**, Urology, Searcy. Born, December 30, 1943, Cambridge, MA. Medical education, University of Pittsburgh, PA, 1970. Internship, Rhode Island Hospital, 1971. Residency, University of Maryland Hospital, 1978. Practice experience, 12 years. Board certified.

**Yates, Terrence R.**, Family Medicine, Searcy. Born January 10, 1962, Fayetteville. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991. Pending certification.

## **MEMBERS-AT-LARGE**

**Calleton, Richard L.**, General Practice, Mena. Born April 12, 1941, Bryn Mawr, PA. Medical education, UAMS, 1976. Internship/residency, Louisiana State University, Shreveport, 1978. Practice experience, 13 years.

**Clark, Barbara J.**, Pediatrics, Pine Bluff. Born February 12, 1957, Columbus, OH. Medical education, UAMS, 1988. Internship/residency, Arkansas Children's Hospital, Little Rock, 1991. Board eligible.

**Griffin, Nancy L.**, Neurology, Texarkana, TX. Born October 31, 1955, Austin, TX. Medical education, University of Texas Medical Sciences Center, San Antonio, 1982. Internship/residency, University of Texas Medical Sciences Center, San Antonio, 1986. Board certified. Practice experience, 4 years.

## **RESIDENTS**

**Hathcock, Stephen A.**, Family Medicine, Little Rock. Born January 12, 1960, St. Louis, MO. Medical education, UAMS, 1989. Internship, Georgetown University Hospital, Washington, D.C. Residency, UAMS.

## **MEDICAL STUDENTS**

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Bonner, Steven H.

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Ceola, Wade M.

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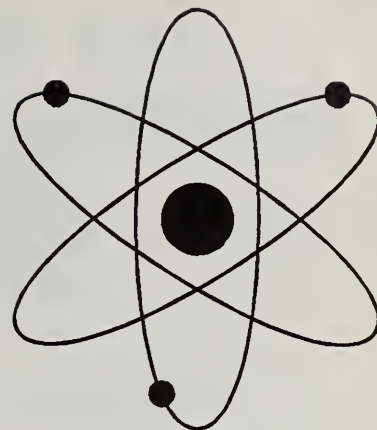
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# Radiological Case of the Month



Charles R. Fielder, M.D.  
David L. Harshfield, M.D.  
Steven R. Nokes, M.D.

## History:

This 27 year-old male presented with chest pain.

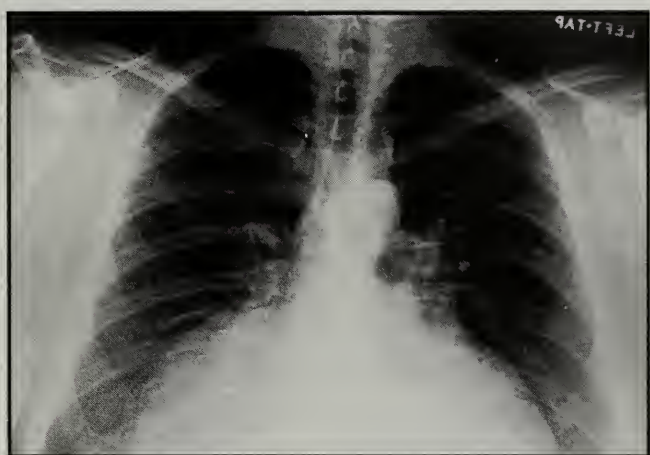


Figure 1a. PA and lateral chest.

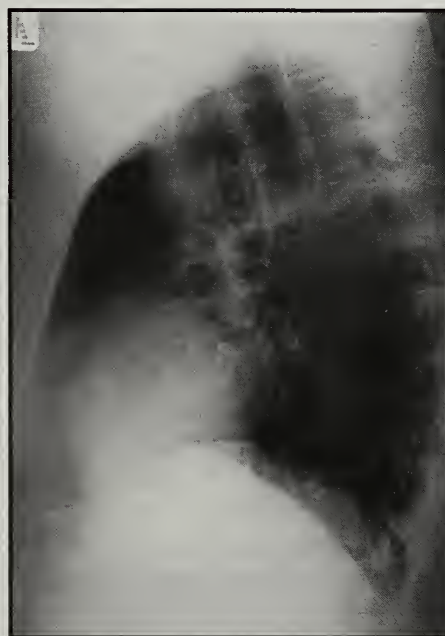


Figure 1b. PA and lateral chest.

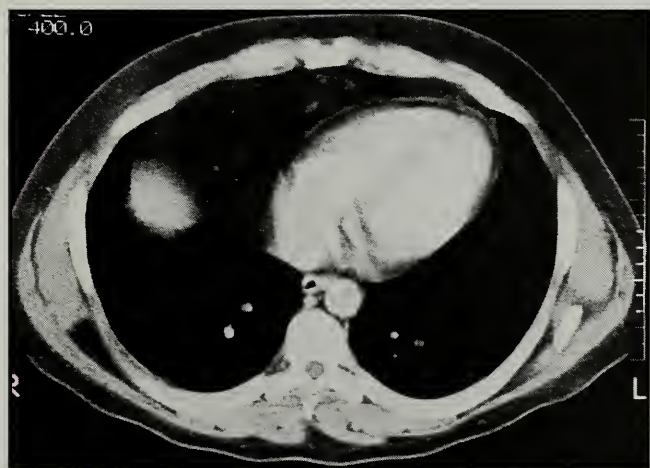


Figure 2a. CT scan of the chest.

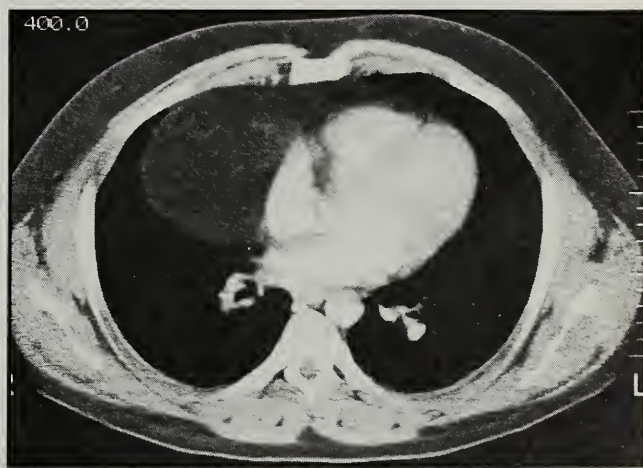


Figure 2b. CT scan of the chest.



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# Morgagni Hernia

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## Radiographic Findings:

The PA and lateral chest films reveal a large, smooth right cardiophrenic angle mass. The CT images demonstrate a large retrosternal fatty mass containing serpiginous vessels.

## Discussion:

The differential diagnosis on the basis of chest films is broad and includes enlarged epicardial fat pad, diaphragmatic tumor, pericardial cyst, cardiac tumor, lymphoma, pulmonary neoplasm, and Morgagni hernia. The CT scan is diagnostic. Only an epicardial fat pad, diaphragmatic lipoma and Morgagni hernia (of omentum) would be composed of fat. The key to the diagnosis is identification of omental blood vessels within the fat. These can be traced back into the abdomen. A fat pad or lipoma would be homogeneous without visible vessels.

Morgagni hernia is a rare congenital anterior diaphragmatic hernia, first described in 1761, that results from the maldevelopment of the septum transversum. While the defect is often bilateral, the heart covers the left opening and herniation of abdominal contents is almost always confined to the right side. There is an association with pericardial deficiency and the hernia contents can enter the pericardial sac. Usually, the hernia contains only omentum, although liver and bowel may be present.

If bowel is herniated, the diagnosis is straightforward. In the past this was confirmed with a barium enema which revealed "tenting" of the colon. When only omentum is present, CT differentiates a Morgagni hernia from an epicardial fat pad or a diaphragmatic lipoma by demonstrating omental blood vessels and absence of the diaphragm. The distinction is helpful, as most surgeons prefer to repair Morgagni hernias using an abdominal approach.

The majority of hernias through the foramen of Morgagni do not give rise to symptoms. Approximately 10% of patients will have epigastric pain or sternal discomfort. Partial intestinal obstruction can occur.

## References

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*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Charles R. Fielder, M.D., is associated with Ludwig, Fielder and Bevans in North Little Rock.*





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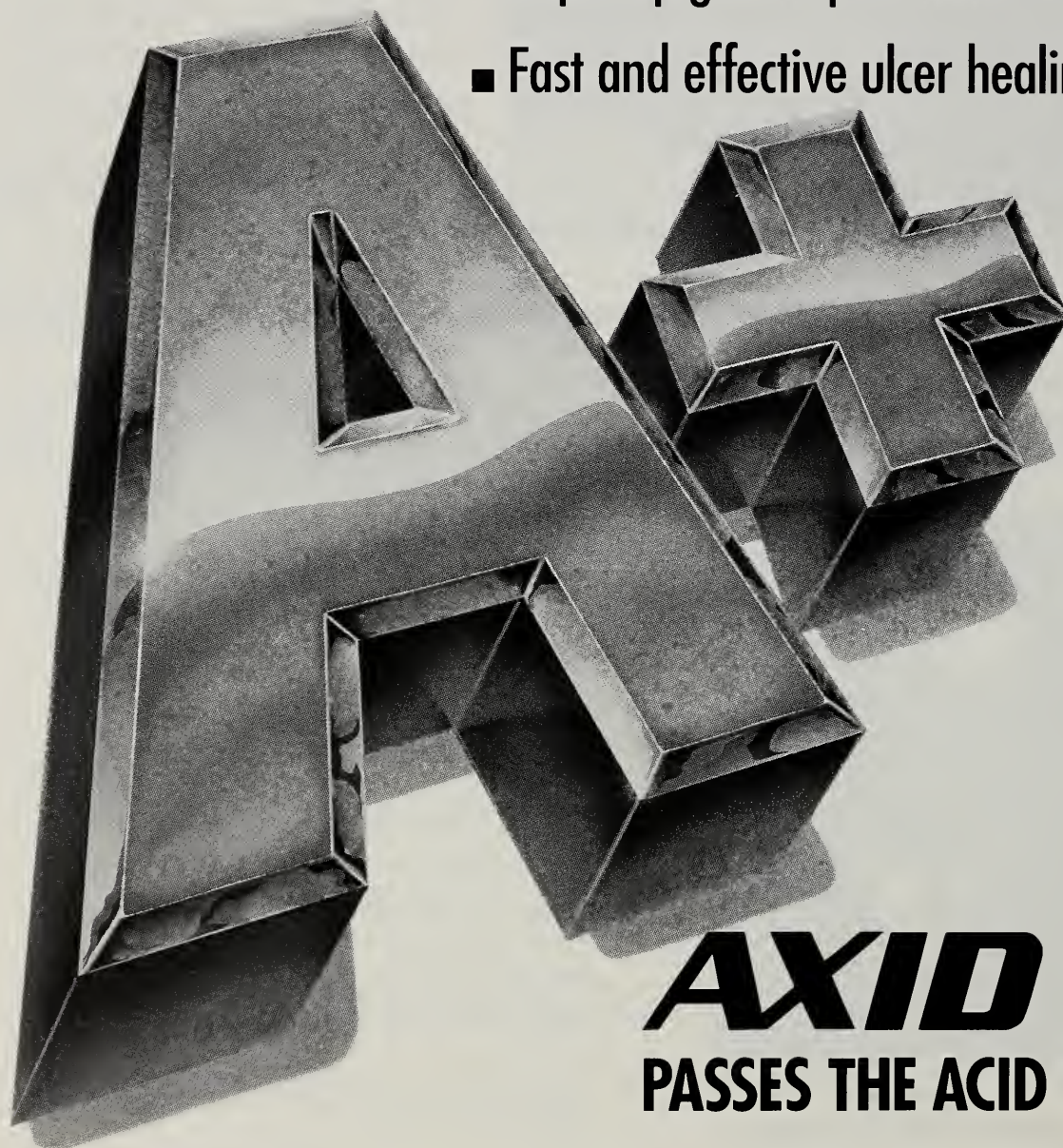


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**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

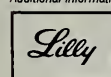
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1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

NZ-2943-B-149347

Additional information available to the profession on request.



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# AMS Newsmakers

**Dr. Raymond C. Bredfeldt**, a family physician from Fayetteville, has been chosen as the 1991-92 Arkansas Family Doctor of the Year. The award was presented at the Arkansas Academy of Family Physicians Annual Scientific Assembly.

Dr. Bredfeldt is program director of the Arkansas Health Education Center Northwest Family Practice Residency in Fayetteville.

**Dr. Steven F. Collier**, a family practice physician from Augusta, recently received the Physician of the Year Award from the Arkansas Association of Home Health Agencies.

Dr. Collier is director of the White River Rural Health Clinic, a board member of the Community Health Centers of Arkansas, the Woodruff County Nursing Home, and the Central Paramedic Service in McCrory. He also serves on the Arkansas State Medical Board.

**Dr. Donald C. Fournier**, an allergy and immunology specialist from Texarkana, Texas, has been elected to Fellowship in the American College of Physicians.

Dr. Fournier is in private practice in Texarkana and is affiliated with Louisiana State University School of Medicine in Shreveport as a clinical assistant professor in Pediatrics and the University of Arkansas for Medical Sciences as an assistant clinical professor in Internal Medicine with the Southwest Area Health Education Center in Texarkana.

**Dr. Hampton Roy**, an ophthalmologist from Little Rock, was recently the honored guest at the 14th Bolivian Congress of Ophthalmology in Cochabamba, Bolivia. He was made an honorary member of the Bolivian Society of Ophthalmology and given a plaque acknowledging his contributions to Bolivian ophthalmology.

In LaPaz, he received an honorary professorship from the University of San Andres. It is the second honorary professorship that he has received. The first was from the University of San Simon in Cochabamba in 1983.

**Dr. John Smith**, a family physician from Conway, was named a member of the Conway Regional Hospital Board of Directors.

**Dr. W. Turner Harris**, director of nuclear medicine at St. Vincent Infirmary Medical Center in Little Rock and a University of Arkansas for Medical Sciences associate clinical professor of radiology, recently received the "Distinguished Alumna Award" from the Arkansas Caduceus Club of UAMS.



# In Memoriam

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## **John W. Ashby, M.D.**

Dr. John Wesley Ashby, a retired family physician from Benton, died Monday, September 9, 1991. He was 81.

Dr. Ashby was a former chief of staff at Saline Memorial Hospital. He was a member of the American Medical Association, the Arkansas Medical Society, the Southern Medical Association, and the Saline County Medical Society.

Survivors are his wife, Mary Alyce Ashby of Benton; a son, Dr. Bob Ashby of Benton; a daughter, Mary Doll Wilkins of Little Rock; and five grandchildren.

## **James W. Branch Sr., M.D.**

Dr. James William Branch Sr., a retired family physician from Hope, died Tuesday, September 3, 1991. He was 82.

Dr. Branch was a founder of the Branch Family Clinic, Branch General Hospital, Heather Manor Nursing Home, Rosewood Nursing Home, and Medical Arts Pharmacy. He was a member of the Arkansas Medical Society and the Fifty Year Club, the American Medical Association, and was a past president of the Arkansas Academy of Family Physicians.

Dr. Branch is survived by a daughter, Marynell Kalkbrenner of Little Rock; two sons, James W. Branch Jr. of Mineola, TX, and Hal W. Branch of San Antonio, TX.; three sisters, Evelyn Moore of Little Rock, Mildred Cook of Chattanooga, TN, and Ann Sanders of Saltville, VA; nine grandchildren; and two great-grandchildren.

## **Thomas M. Durham, M.D.**

Dr. Thomas M. Durham, a physician from Hot Springs, died Friday, August 16, 1991. He was 71.

Dr. Durham was a member of the Arkansas Orthopaedic Society, Arkansas Medical Society, American College of Surgeons, American Medical Association, and past president of the Garland County Medical Society.

Dr. Durham is survived by his wife, Sue Durham; four sons, James M. Durham of Burke, Va., Dr. Charles M. Durham of Tuscaloosa, Ala., John T. Durham of Charlotte, NC, and David C. Durham of Beaufort, SC; two daughters, Patricia D. Smith of Aiken, SC, and Carol M. Durham of Hot Springs; and 10 grandchildren.

## **Mrs. Louise Woodrum Harris**

Mrs. Louise Woodrum Harris, of Danville, died Sunday, August 11, 1991. She was 65.

Mrs. Harris was a member of the Arkansas Medical Society Auxiliary and the John Ed Chambers Hospital Ladies Auxiliary.

Mrs. Harris is survived by her husband, Dr. Walter P. Harris; a son, Tommy D. Harris of Danville; two daughters, Mary Alice Harris of Danville and Patricia Gail Harris of Phoenix, Ariz., a brother, Robert Woodrum of Harrisburg; and two grandchildren.

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# Resolution

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## **Charles C. Ault, M.D.**

Whereas, the membership of the Pulaski County Medical Society notes with genuine sorrow the recent death of our respected colleague, Charles C. Ault, M.D.; and

Whereas, Dr. Ault was an active member of this organization for 25 years, contributing substantially to its betterment; and

Whereas, he was greatly respected by his fellow physicians for his professional ability and his compassionate care of psychiatric patients at Ft. Roots Veterans Administration Hospital; be it therefore

*RESOLVED*, that this resolution be adopted and filed in the permanent files of the Society; and

*RESOLVED*, that a copy be mailed to Dr. Ault's family as a token of our sincere sympathy; and

*RESOLVED*, that a copy be provided to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
August 21, 1991

By Order of the Memorials Committee  
Marlon J. Doucet, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

## **Edwin F. Gray, M.D.**

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the tragic death one of our most esteemed colleagues, Edwin F. Gray, M.D.; and

Whereas, Dr. Gray was a loyal member of this Society for 56 years serving in numerous positions of leadership including the office of President in 1955; and

Whereas, Dr. Gray's pioneering efforts in his chosen field of Radiology earned him the respect and admiration of his colleagues and patients alike; be it therefore

*RESOLVED*, that this resolution be adopted and made a part of the permanent records of this Society; and

*RESOLVED*, that a copy be forwarded to Dr. Gray's family as a token of our heart-felt sympathy; and

*RESOLVED*, that a copy be sent to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
August 21, 1991

By Order of the Memorials Committee  
Marlon J. Doucet, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.



## **James H. Fraser Jr., M.D.**

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death of our respected colleague, James H. Fraser Jr., M.D.; and

Whereas, this organization was strengthened by his faithful and supportive service as an Active Member for over 10 years; and

Whereas, Dr. Fraser's caring and unselfish dedication to his profession and his patients will be long remembered; be it therefore

*RESOLVED*, that this resolution be adopted and placed in the permanent archives of this Society; and

*RESOLVED*, that a copy of this resolution be sent to Dr. Fraser's family as an expression of our sincere sympathy; and

*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
August 21, 1991

By Order of the Memorials Committee  
Marlon J. Doucet, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

## **James Albert Johnson, M.D.**

Whereas, the members of the Pulaski County Medical Society are saddened by the recent death of our respected colleague, James Albert Johnson, M.D.; and

Whereas, he was a faithful member of this Society for over 35 years; and

Whereas, Dr. Johnson's commitment to his profession and his community was evidenced by his many hours of service as Chief of Staff at Rebsamen Regional Medical Center, as team doctor for Jacksonville High School, and as a board member of numerous civic organizations; be it therefore

*RESOLVED*, that this resolution be adopted and placed in the permanent files of this Society; and

*RESOLVED*, that a copy be forwarded to Dr. Johnson's family as an expression of our heart-felt sympathy; and

*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
August 21, 1991

By Order of the Memorials Committee  
Marlon J. Doucet, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.



### The definition of high technology...

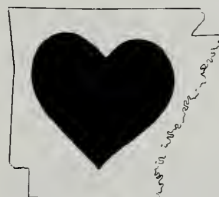
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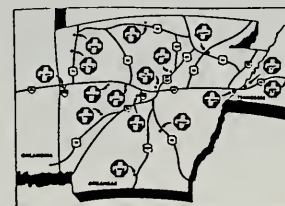
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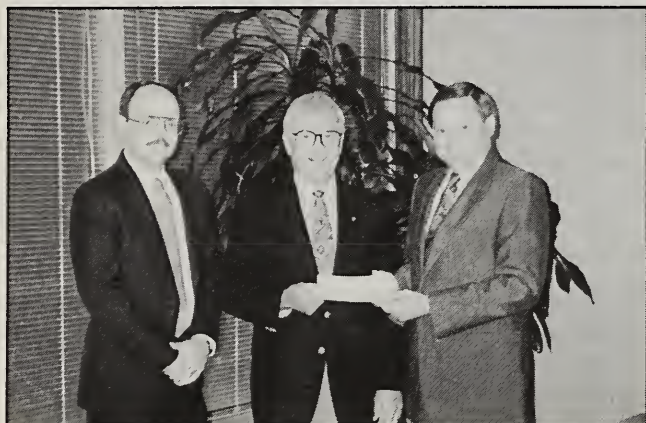


# Medicine in the News

## Health Care Access Foundation Update

As of August 1991, the Arkansas Health Care Access Foundation has provided free medical services to 3,053 medically indigent persons.

The program has 1,472 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.



*Dr. Joe Martindale, director of the PHC, accepts a donation for \$5,000 from Mr. Tom Hesselbein (left) and Mr. Nicholas Nelson (right) of the St. Paul Fire and Marine Insurance Company.*

## PHC Receives \$5,000 Contribution

A check for \$5,000 was presented to Dr. Joe L. Martindale, director of the Arkansas Medical Society's Physicians' Health Committee, by Mr. Nicholas Nelson and Mr. Tom Hesselbein of the St. Paul's Little Rock office. Mr. Nelson, vice president and general manager of the Little Rock office, said the contribution to the Arkansas program complements the company's contribution of \$99,000 to the American Medical Association's Physicians' Health Program. "This state's and the national efforts fit with our human factors program developed specifically for doctors," Mr. Nelson said. "Ultimately, we believe these types of programs will help reduce medical liability losses and positively impact premiums."

St. Paul Fire and Marine Insurance Company recognizes the valuable work of Dr. Martindale and the Physicians' Health Committee and supports the committee because they believe that a need exists for the program.

## NCI "Prescribe for Health" Program

The National Cancer Institute (NCI) recently announced a major collaborative effort to improve early cancer detection by primary care physicians called "Prescribe for Health."

During the next four years, NCI will award grants to physicians and research institutions to evaluate methods for implementing the NCI's working guidelines for early cancer detection. This is the first program to fund medical intermediary organizations to improve physician skills in detecting early cancers.

NCI has formulated a set of early detection guidelines for seven types of cancer: breast, skin, colorectal, prostate, testicular, oral cavity, and uterine cervix. These guidelines are intended to encourage early detection through the increased use of physical examinations and diagnostic tests.

This is the largest primary care early detection initiative in the country, NCI said. More than \$7.5 million will be spent for this program.

## Three Part Teleconference on Depression

The American Medical Association and the National Institute of Mental Health's Depression, Awareness, Recognition and Treatment Program (D/ART) are sponsoring three teleconferences on Depression in Primary Care to be aired at participating hospitals and will be at no cost to the attendee.

The first teleconference, airing October 24, 1991, addresses epidemiology, etiology, and diagnosis. Among other things, three cases will be presented to show different presentations of depressive symptoms which might be seen by primary care physicians.

The second teleconference, airing November 21, 1991, will present information on pharmacological and psychotherapeutic treatments of depression, as well as guidelines for referring patients to mental health specialists.

The final program, airing December 11, 1991, will focus on special populations, including elderly patients and adolescents and postpartum depression. The program will address differentiation between depression and normal mood variations and keys for making that distinction.

For content and hospital location information, contact Mary Ayesse, MSW, MPH or Patrick McGuffin, Ph.D., Department of Mental Health, American Medical Association, (312) 464-5066.



## AMA Adopts Policy on Hepatitis B Virus

The American Medical Association recently adopted as it's policy the following recommendations concerning health care workers and hepatitis B virus infection:

- ☐ That any health care worker who is infected with HBV and in whom HBeAg can be demonstrated should abstain from performing invasive procedures that pose an identifiable or measurable risk of transmission.
- ☐ That all health care workers who are at risk of infection with hepatitis B virus (HBV) should be fully immunized with HBV vaccine.
- ☐ That for the purposes of these recommendations, a "health care worker" be considered as any person involved in patient care in a paid capacity or as a volunteer and as a student, resident, trainee, or trained worker.

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# Things To Come

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## October 24-26

**Sexual Desire Disorders: Everything You Wanted to Know But Lacked the Desire to Ask.** Holiday Inn Crowne Plaza, Kansas City, MO. Sponsored by The Menninger Clinic. Fees: \$235 per person; \$195 per person for two or more. For more information, contact Brenda Vink at (800) 288-7377, ext. 5991.

## October 28-31

**Primary Care Update.** Hyatt Regency New Orleans, LA. Sponsored by the Interstate Postgraduate Medical Association of North America. Category I credits available. Fees: \$225, advance registration; \$250, on site registration; \$35, residents & interns; \$50, allied health professionals. For more information, call (608) 257-1401.

## October 28-November 1

**Environmental Medical Issues.** St. Louis Marriott Pavilion Downtown, MO. Sponsored by the American College of Occupational Medicine. CME credits available. For more information, call (708) 228-6850.

## November 6-8

**Comprehensive Management of HIV Disease: A Clinical Preceptorship for Physicians.** Sponsored by the Delta Region AIDS Education and Training Center at the Louisiana State University School of Medicine, New Orleans. For more information, contact Gwendolyn Foxworth or Daphne LeSage at (504) 568-3855.

## November 7-8

**National Conference on Alcohol & Other Drug Abuse: Changing Lives Through Research & Treatment.** Meharry Medical College, Nashville, TN. Sponsored by the Meharry Medical College. For more information, call (800) 669-1269.

### Little Rock

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## November 9-14

**44th Annual Meeting of the American Association of Blood Banks.** Baltimore Convention Center, Baltimore, MD. For more information, contact Marcia Lane at (703) 528-8200.

## November 16-19

**SMA's 85th Annual Scientific Assembly.** Georgia World Congress Center & Atlanta Hilton & Towers, Atlanta, GA. Sponsored by the Southern Medical Association. Fees: \$75.00, member physicians. For more information, call (800) 423-4992.

## December 7

**8th Annual Clinical Update in Pulmonary Medicine.** Caesars Hotel, Atlantic City, NJ. Sponsored by the Department of Pulmonary Medicine, Deborah Heart and Lung Center of the Center for Bio-Medical Communication, Inc. Category 1 CME credits available. For more information, contact Robert Silver at (201) 385-8080.

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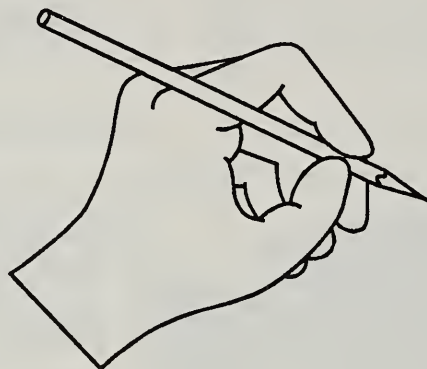


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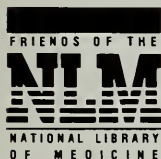


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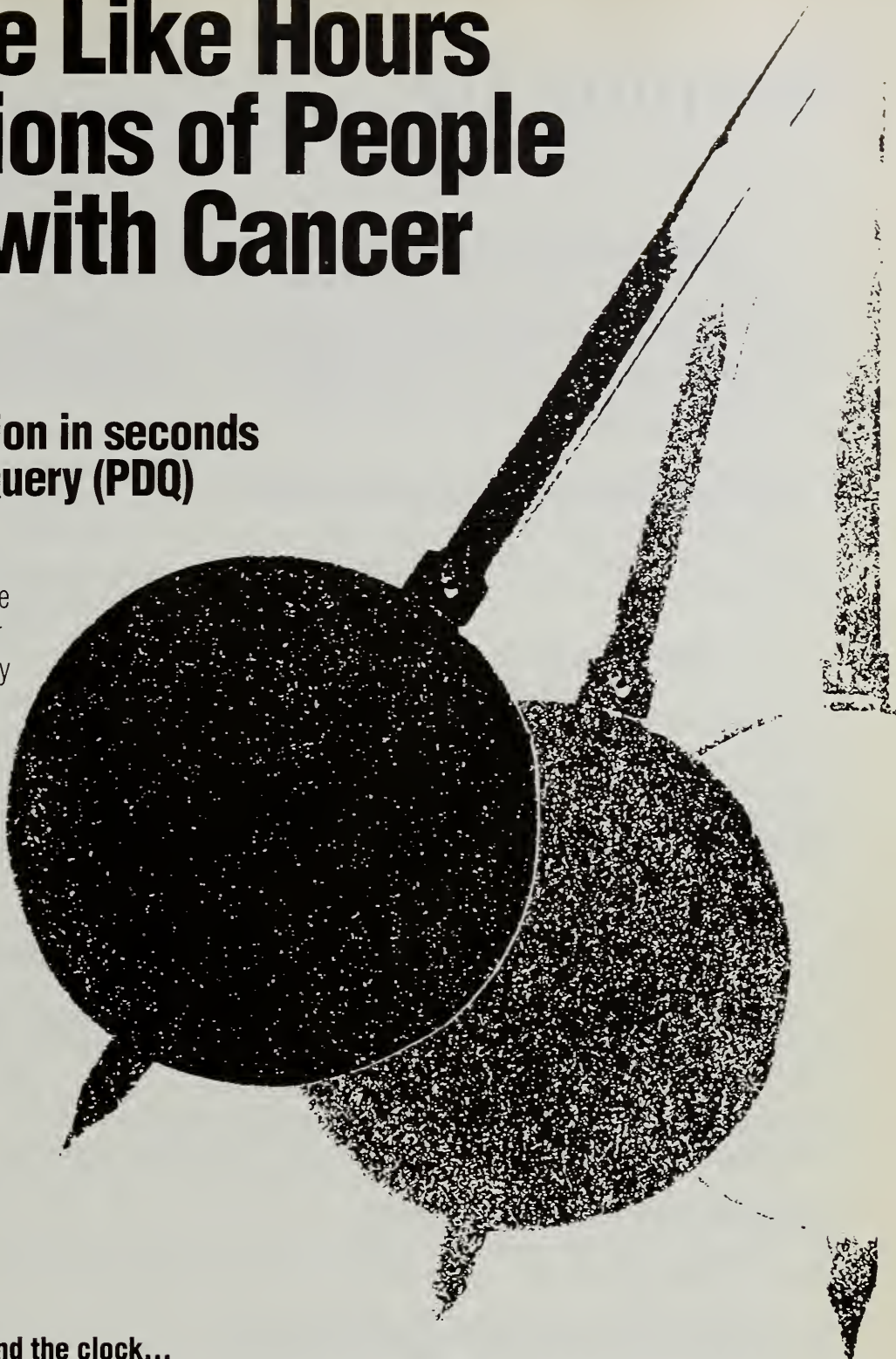
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# Keeping Up

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## **Neuroradiology Update 1991**

*October 19-20, John Gilbreath Educational Center, Baptist Medical Center, Little Rock.* Sponsored by the Arkansas Chapter of the American College of Radiology. Fees: \$100.00. Eight hours of CME Category I credit hours available. For more information, contact Peggy Buice at (501) 663-2244.

## **Arkansas Physicians Opportunity Fair**

*October 24, University of Arkansas for Medical Sciences.* More information will be forthcoming. For more information, contact Tom South at (501) 686-5813.

## **Dying, Death & Grieving: A Social Process**

*November 5, 9:00 a.m.-3:30 p.m., Arkansas Services Center, Jonesboro.* Sponsored by the George W. Jackson Community Mental Health Center. Fees: \$20, pre-registration; \$25, at the door. For more information, call (501) 972-4014.

## **Arkansas Orthopaedic Society's Fall Meeting**

*November 8-9, Holiday Inn Civic Center, Fort Smith.* For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058.

## **The Seasonal Child**

*December 3, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building.* Sponsored by Arkansas Children's Hospital. Category I credit available. Fee: \$25. For more information, call (501) 320-1248.

## **Arkansas Hand Club Annual Meeting**

*May 8-9, 1992, Gaston's White River Resort, Lakeview.* For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.*

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC*

*Medical Grand Rounds, Fridays, 12:00 noon, VAMC*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium*

*Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457*

*Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom*

*Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium*

*Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom*

*Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom*

*Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided*

*Journal Club, Tuesdays, 12:00 noon, Dunkerton/AP&L room. Lunch provided*

*Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served*

*Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided*

*GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided*

*Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Pathology classroom. Lunch provided*



*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon. Lunch provided  
*Sleep Disorders Case Conference*, every other Thursday, Video Production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon. Sandwich buffet served

## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., conference room 1  
*GI Conference*, 4th Friday, 12:00 noon, call BMC at 227-2672 for location  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tues., 6:45 a.m.; 2nd & 4th Thurs., 4:00 p.m., UAMS Educ. Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neruosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135



*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## EL DORADO - AHEC

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## FAYETTEVILLE - AHEC NORTHWEST

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## FORT SMITH - AHEC

*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## JONESBORO-AHEC NORTHEAST

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th & 5th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.



*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## PINE BLUFF-AHEC

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

## TEXARKANA-AHEC SOUTHWEST

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of June, July, and August were:

Denver L. Barger	Little Rock	W. Jean Matchett	Little Rock
Michael E. Barnett	Heber Springs	Joseph W. Matthews	Little Rock
Allen L. Beachy	Fort Smith	Charles M. McClain	Batesville
Robert B. Casper	Little Rock	Robert N. McGrew	Little Rock
Janet R. Cathey	North Little Rock	Riley A. Middaugh	Little Rock
Michael E. Crawley	Jonesboro	Walter H. O'Neal	North Little Rock
Wayne P. Enns	Paris	Richard C. Pillsbury	El Dorado
Joseph M. Gettys	Little Rock	Kevin L. Pope	Fayetteville
Wilbur M. Giles	Little Rock	Robert A. Porter	Little Rock
William C. Glover	Little Rock	John F. Redman	Little Rock
Henry H. Good	Little Rock	Raul E. Rivera	Fort Smith
Randal F. Hundley	Little Rock	Allen R. Rozzell	Little Rock
Michael B. Johnson	Little Rock	George T. Schroder	Little Rock
Stacey M. Johnson	Mountain Home	John E. Slayden	Little Rock
Edward J. Jones	Batesville	George W. Smith	El Dorado
Fred R. Jordan	North Little Rock	Marc H. Trager	Mountain Home
John W. Joyce	Little Rock	Phillip M. Utley	Jonesboro
Robert G. Lassonde	Jonesboro	Kanaka Vasudevan	Helena
Ralph E. Ligon	Pine Bluff	Parthasarathy Vasudevan	Helena
Jimmie E. Lytle	Batesville	Bruce A. White	Malvern
Stephen K. Magie	Conway	Andre B. Whiteley	Springdale
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# Advertisers Index

Advertising Agencies in Italy

American Medical Finance Inc. ....	209
<i>Ivy-Seamans Communications, Inc.</i>	
American Physicians Insurance Exchange ....	inside front
Arkansas Express Claims .....	227
Collom & Carney Clinic Association .....	223
CompuMedics, Inc. ....	249
Eli Lilly & Company .....	244
<i>Garrison, Jasper, Rose &amp; Company</i>	
Eli Lilly & Company .....	245
Tommy Farrell Associates .....	243
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	253
Freemyer Collection Systems .....	253
I CARE of Arkansas .....	back cover
Medical Protective Company .....	224
<i>Ferguson Advertising, Inc.</i>	
Medical Protective Company .....	247
Mediquik Walk-In Clinics .....	249
MED/PAC - Formcraft of Arkansas, Inc. ....	237
MEDX .....	251
Mississippi Methodist Rehab Center .....	213
<i>Maris, West &amp; Baker, Inc.</i>	
Palisades Pharmaceuticals, Inc. ....	217
<i>Design &amp; Advertising</i>	
Radiology Consultants .....	214
Rather, Beyer & Harper .....	253
Reed & Carrick .....	inside back
<i>Gross Townsend Frank Hoffman</i>	
State Volunteer Mutual Insurance Company .....	210
<i>The Maryland Group</i>	
U.S. Air Force .....	240
<i>Bozell, Inc.</i>	
University Cardiothoracic Surgery .....	249

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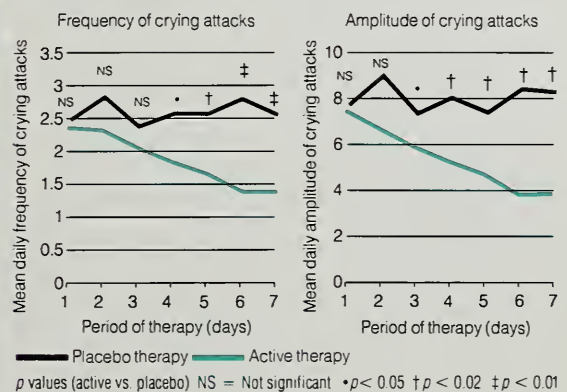
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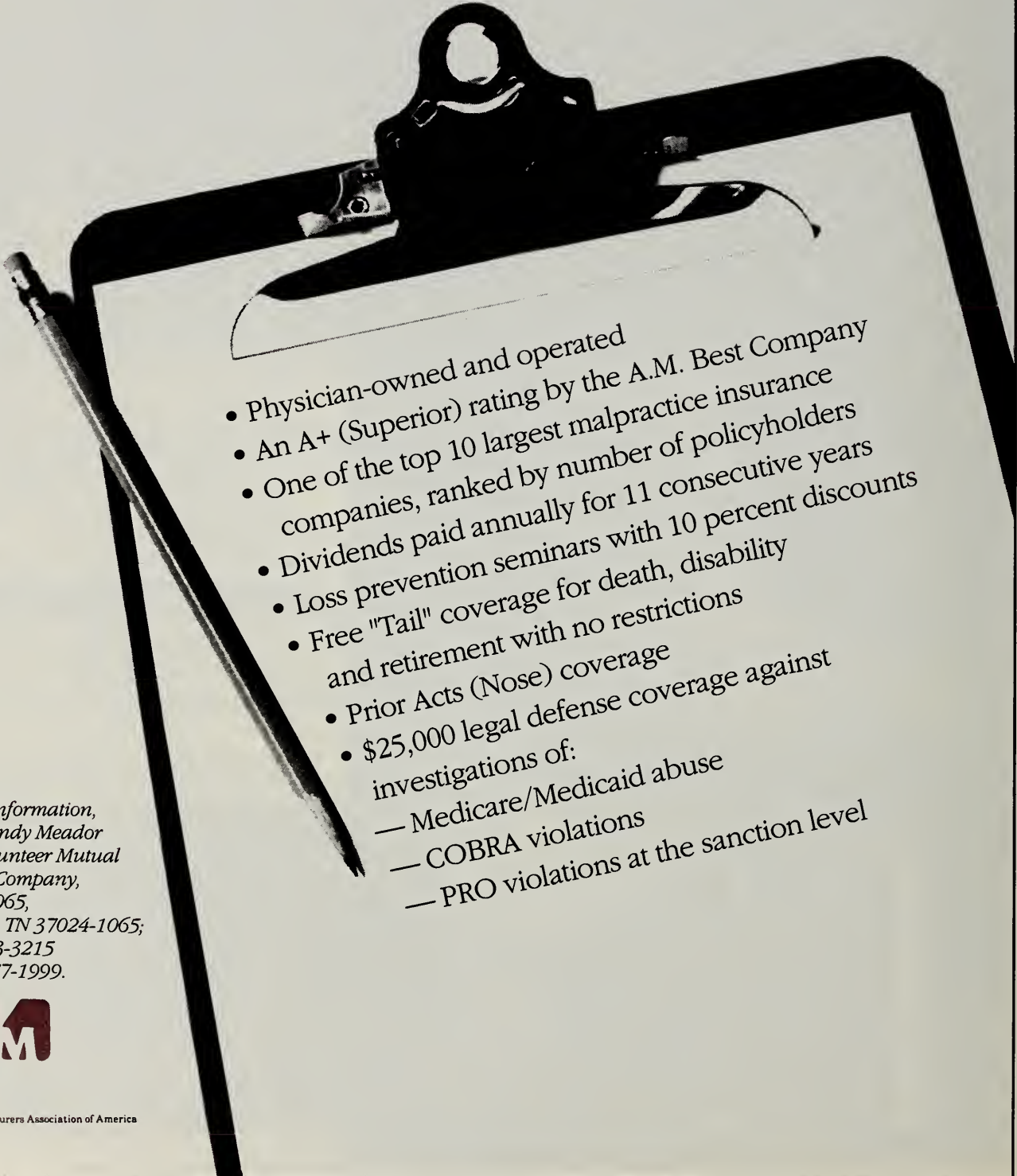
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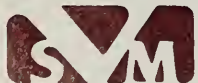


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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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## CONTENTS

### FEATURES

- |     |   |
|-----|---|
| 264 | Access to Health Care for Children and Adolescents<br><i>Guest Editorial</i><br>Joycelyn Elders, M.D.                     |
| 267 | Metastatic Malignant Insulinoma: Debulking for Palliation of Symptoms<br>A.H. Rusher, M.D., F.A.C.S., Kelton Henson, M.D. |
| 271 | Evaluation of Contact Dermatitis Using the TRUE Patch Test<br>R.W. Wright, R.P.H., M.H.S.A.                               |
| 274 | Survey Underscores Changing Attitudes of Young Physicians<br>Phillip Miller   |
| 276 | Old Ledger Records Rural Doctor's Work<br>Charlotte Schexnayder   |
| 279 | The Florida HIV Dental Case<br>Donald C. Fournier, M.D.   |
| 284 | Failure to Diagnose Myocardial Infarction<br><i>Loss Prevention Case Study</i><br>Cindy Conkle, R.N., B.A., A.R.M.        |

### DEPARTMENTS

- |     |                                |
|-----|--------------------------------|
| 282 | AIDS in Arkansas Statistics    |
| 287 | New Members                    |
| 290 | AMS Newsmakers                 |
| 293 | In Memoriam                    |
| 294 | Medicine in the News           |
| 295 | Radiological Case of the Month |
| 298 | ECG of the Month               |
| 300 | Things to Come                 |
| 302 | Keeping Up                     |

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# Access to Health Care for Children and Adolescents

Joycelyn Elders, M.D.\*

## High Risk Behaviors

Today, the threats to young people's health, unlike those which were disease related a century ago, are largely attributable to lifestyle. High risk behaviors such as smoking, drinking, unprotected sexual intercourse and substance abuse, often begun during adolescence, jeopardize the health and welfare of our young people. The consequences of those behaviors can have a lasting impact.

Look at these startling statistics:

- ☐ Nearly one in four children under the age of six live in poverty.
- ☐ Over two million children are reported as abused or neglected.
- ☐ More than 1.1 million girls, ages 10 to 19, become pregnant.
- ☐ 2.5 million teenagers contract a sexually transmitted disease each year.
- ☐ Approximately 7,500 adolescents 10 to 19 years of age are killed in motor vehicle accidents.
- ☐ More than one-half million 10 to 17 year olds try cocaine.
- ☐ Nearly one million youth drop out of school.

- ☐ More than one out of ten adolescents from 10 to 19 will be arrested for a juvenile crime.
- ☐ AIDS has increased 40 times in the past two years for this age group.
- ☐ One in seven adolescents is a problem drinker.<sup>1</sup>

These facts should make us realize that the children on whom we will depend for decisions in the 21st century, face problems which threaten their ability to become healthy adults, capable of leading full, productive lives and maintaining our nation's productivity and competitiveness. Business leaders and educators agree that the labor force of the future will need educated, healthy adults, if the United States is to remain competitive in the global economy.

## Barriers to Health Care

Children often face insurmountable barriers to adequate care. Lack of knowledge, lack of transportation, lack of money, lack of available services, and lack of awareness of preventative health care often keep them from receiving the services they deserve. Rural children often face non-existent health services or must travel long distances to obtain any health care.

## Six Prescriptions

The problems described above offer cause for concern, but they are not insurmountable. To reverse these frighten-

---

\* Dr. Elders is the director of the Arkansas Department of Health in Little Rock.



ing trends, we must begin early in a child's life, to provide the necessary "prescriptions." I advocate six prescriptions:

1. Universal, early childhood education to prepare our children to learn and achieve upon entering school.
2. Parenting education for the parents of today and the parents of tomorrow. This program must be designed around the busy lives of working parents to help them become better parents.
3. Increasing male responsibility to instill in our young men the responsibilities that are associated with early sexual activity.
4. Comprehensive health and family life education to be taught starting in kindergarten and continuing through high school.
5. Opportunities for higher education guaranteeing all children who make good grades, exhibit good citizenship and have low family income an opportunity to attend college.
6. Comprehensive School Based Health Services. If we are to make a difference in the morbidity and mortality of our most valuable resource, we must be willing to provide their unmet health care needs. Every major educational organization, task forces or health organization in the past five years has recommended comprehensive health education programs in our schools from kindergarten through 12th grade. Yet, in Arkansas, only 15 of our schools offer such a comprehensive program. Primary, preventive health services are available to less than 60% of our children. We are using band aid approaches when we need major surgery. We must make the classrooms of our schools our operating suites to meet the challenge of addressing the health needs of our youth. During the months of September through May of each year, one out of every five of our citizens are in our public schools. The school's ability to reach children and youth disenfranchised from the health care system and at highest risk for poor health and potentially health threatening behaviors is unmatched.

The advantage of comprehensive school based health services are clear. School health service programs:

- ☐ Are equitable. They offer an entry point into the health care system for all children.
- ☐ Can provide a broad range of comprehensive, preventative services not reimbursed by a majority of health insurance policies.
- ☐ Are confidential and therefore user friendly for troubled

adolescents. The services are provided in a trusting and familiar environment.

- ☐ Are convenient. Teenagers are more likely to walk in spontaneously in the school setting where no appointment is necessary.

I believe we cannot make sufficient advances in educational reform until our children are healthy. We cannot educate children if they are not healthy and we cannot keep them healthy if they are not educated. I urge you, as members of the medical community of this state, to join me in urging your local school district boards of directors to implement comprehensive health education in your public schools for the children of this state. Only through the development of preventive, primary, acute and specialty care for all of our children can we rest easier on what the future has to hold for us during the 21st century. We have the resources, we have the know how, and now we must make the commitment.

## Reference

1. "Caring for Kids" National Governor's Association State Policy Report, April 1991; "Code Blue Report" National Commission of the Role of the School and the Community in Improving Adolescent Health, 1990; "Children 1990" Children's Defense Fund. ■

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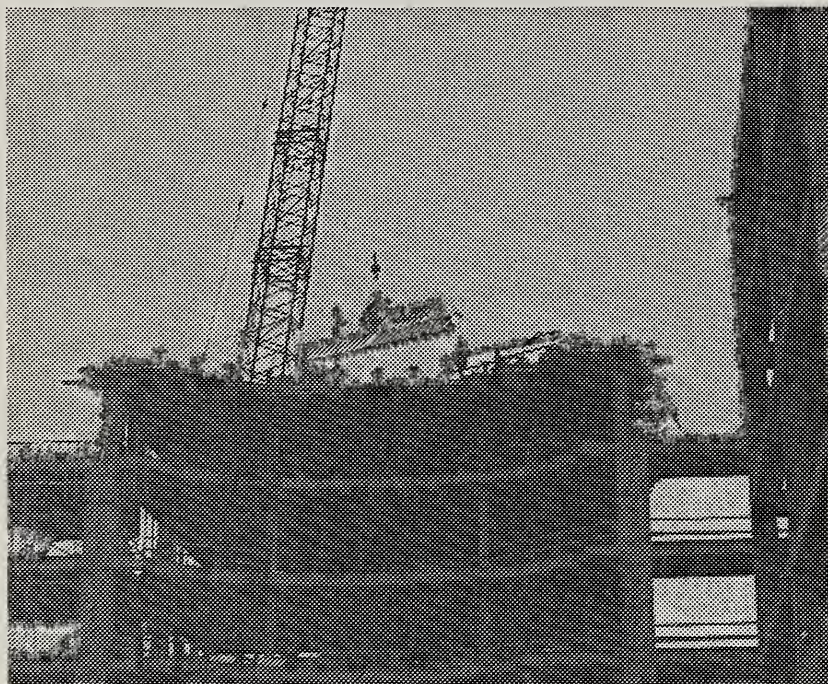
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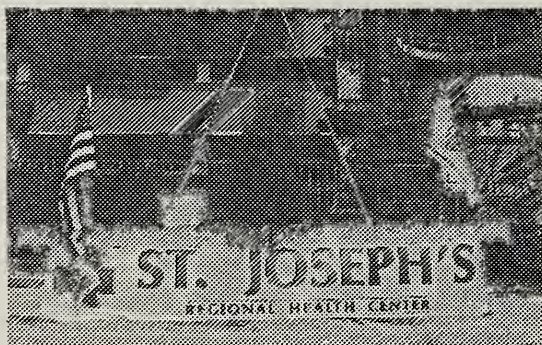


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# Metastatic Malignant Insulinoma: Debulking for Palliation of Symptoms

A.H. Rusher, M.D., F.A.C.S.\*

Kelton Henson, M.D.\*\*

*This unusual case is that of a patient who had recent onset of sudden severe hypoglycemic symptoms. CT scan and arteriography demonstrated a large, widely metastatic tumor of the pancreas involving liver, regional lymph nodes, and the superior mesenteric vein. Tissue diagnosis was obtained by percutaneous needle biopsy of a liver metastasis. The patient had to be maintained on a continuous D10W drip until a successful debulking total pancreatectomy was done. She is currently at home on pancreatic enzyme replacement.*

A variety of endocrine and exocrine tumors may involve the pancreas. We can broadly classify these as functioning and non-functioning tumors on the basis of hormone production. For every patient with a functioning islet cell tumor, there will be 125 patients with non-functioning pancreatic ductal adenocarcinoma.<sup>1</sup> The usual metastatic carcinomas of the exocrine pancreas are not deemed curable and most are only marginally palliated by surgery.<sup>2</sup> Endocrine tumors on the other hand, are usually benign and create symptoms based on the activity of the substances they produce. Among the more common tumors associated with the pancreatic islets in decreasing order of frequency are the insulinomas, gastrinomas, glucagonomas, PTH-like producing tumors, VIPomas, somatostatinomas, and ACTH-producing tumors.<sup>1,3,7</sup> Surgery for these unusual tumors has been well described.<sup>4</sup>

This particular case however, presents a patient with not only a malignant endocrine tumor, but also one that was widespread in the peripancreatic area with superior mesenteric vein thrombosis and multiple liver metastases (see Figure 1a).

We believe our experience is significant enough to remind readers of the value of debulking such a tumor even in the presence of advanced malignant disease.

## Case Report

A 52-year-old white woman was admitted to the hospital for evaluation following a minor motor vehicle accident. Her blood glucose was noted to have been 34 mg/dl in the emergency room. She was not diabetic and was on no insulin nor hypoglycemic agents. An H2 blocker was her only medication for recent complaints of heartburn. Physical examination was significant for the loss of orientation to place and time as well as for a moderate global aphasia. CT scan of her head was normal as were her CBC and electrolytes. She was admitted to the ICU on a D10W drip at 75 cc/hr to maintain her blood glucose above 70 mg/dl. The patient's aphasia resolved after 12 hours. It was determined serologically that she had normal function of thyroid, adrenals, and liver. Assays for glucagon, somatostatin, and VIP were negative, however, insulin levels drawn during her hypoglycemia were inappropriately high. A CT scan of the abdomen demonstrated a large mass in the head and body of her pancreas (Figure 2), and several 2 cm lesions in both lobes of her liver. A needle biopsy of one of the liver nodules was consistent with a malignancy of neuroendocrine origin. An abdominal arteriogram with runoff was then done. A large hypervascular mass within the head of the pancreas was shown on arterial phase (Figure 3) and the venous phase revealed a complete obstruction of the superior mesenteric

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\* Dr. Rusher is a general surgeon and affiliated with Jonesboro Surgical Associates.

\*\* Dr. Henson is a resident at the Area Health Education Center in Jonesboro, Arkansas.



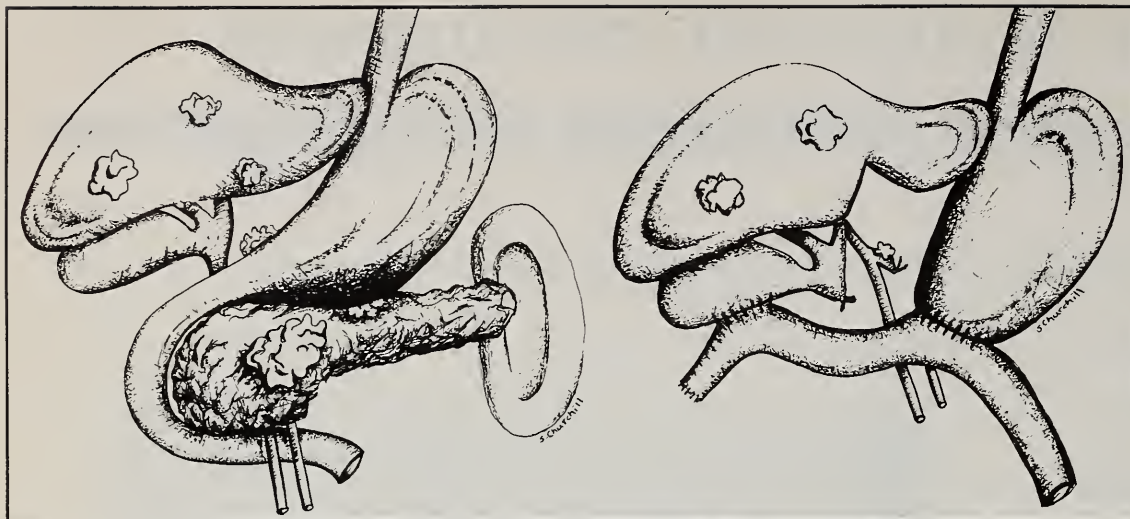


Figure 1. Schematic diagram of (a) operative findings and (b) post-operative anatomy.

vein with collateral flow into the portal vein via right colic venous tributaries (Figure 4).

The patient was later taken to the operating room where a total pancreatectomy was successfully completed in six hours. The resection included the distal antrum of the stomach, the distal common bile duct, the duodenum, the spleen, the total pancreas, adjacent removable lymph nodes, and a wedge of accessible liver metastases (Figure 1b).

Reconstruction was with a cholecystojejunostomy and

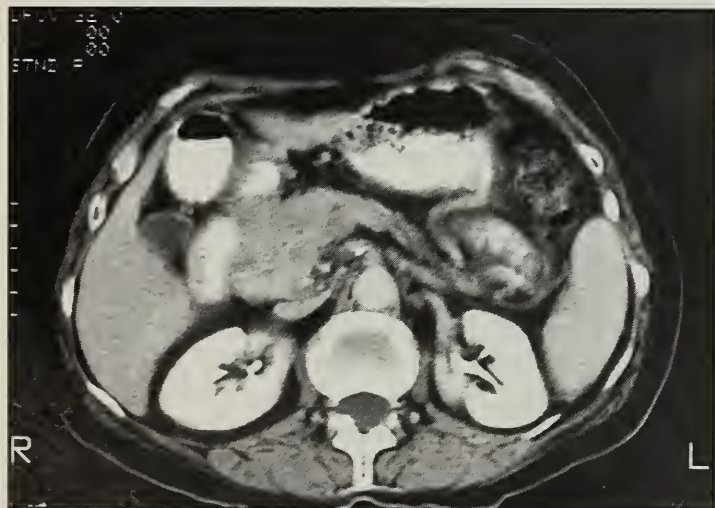


Figure 2. CT scan of abdomen showing large mass in head and body of pancreas.

gastrojejunostomy to the same limb of the small bowel. The occluded portal vein was carefully dissected leaving a small remnant of tumor but it was not bypassed even though some of the collateral veins were sacrificed out of necessity. Her estimated operative blood loss was 1,000 cc and two closed suction drains were left in the pancreatic bed postoperatively.

drains were removed after approximately three weeks and her wounds healed primarily without complications. She was discharged home on a regular diet with only pancreatic enzyme replacement and Amitriptyline for an associated postoperative depression.

## Discussion

Metastatic malignant insulinomas are rare clinical entities. Only 10% of all insulinomas are malignant and of these over 50% are metastatic.<sup>3,5,7</sup> The tumors are typically slow-growing and there is only marginal evidence that any chemotherapy including streptozotocin, somatostatin, 5-FU, or diazoxide is of particular benefit.<sup>6</sup> For insulin-producing tumors confined to the pancreas, a resection of a portion or even all of the pancreas is considered sufficient for cure. The benign insulin tumors, once found, can even be enucleated to correct the patient's debilitating hypoglycemic episodes.

This case illustrates the absolute need of our patient for a continuous parenteral infusion of D10W at a rate of no less than 75 cc/hr in order to minimally maintain her blood glucose above 70 mg/dl. After considering the diagnostic findings of widespread metastatic malignant insulinomas on CT scan, we decided that a debulking total pancreatectomy should be

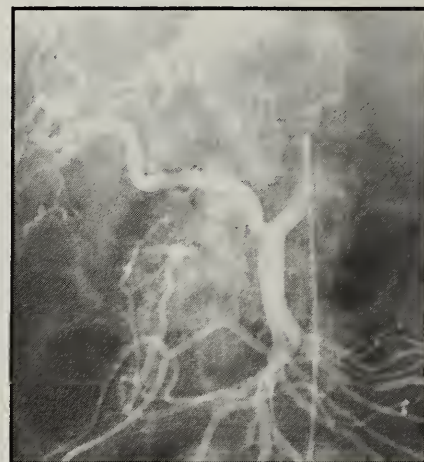


Figure 3. Superior mesenteric arteriogram showing large tumor "blush" in pancreas.

The subsequent hospital course was relatively uneventful with the eventual maintenance of her blood glucose near 100 mg/dl on small, frequent meals. A large output from her abdominal drains, initially as high as three liters per day of ascitic fluid, gradually decreased over a period of 10 days. This drainage was thought to be secondary to increased portal pressure after the surgical ligation of portal venous collaterals. Her



done if technically possible. An arteriogram done to assess the vascular supply and resectability of the large tumor showed to our surprise an occluded superior mesenteric vein with venous collaterals on venous phase of the study. We have not seen this previously described with insulinomas.

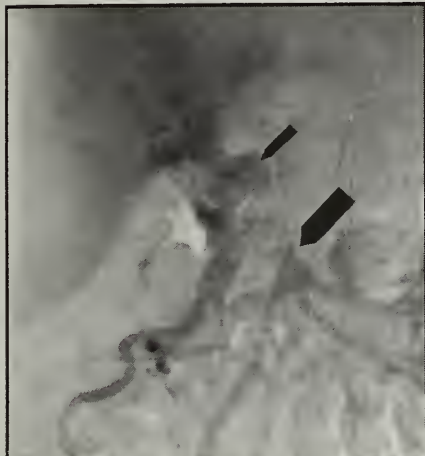


Figure 4. Venous phase of arteriogram showing occluded superior mesenteric vein (large arrow) and collateral filling of portal vein (small arrow).

have controlled her symptoms due to costs of treatment, undesirable side effects, lack of patient compliance, and the basic severity of her disease and its symptoms. The successful palliation of her hyperinsulinemia by surgical debulking has given our patient the greatest opportunity to return to a satisfactory and acceptable lifestyle.

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# Evaluation of Contact Dermatitis Using the TRUE Patch Test

R.W. Wright, R.P.H., M.H.S.A.\*

*Patch testing is a dermatological diagnostic procedure for contact dermatitis utilizing selected allergens. It has been suggested that suspected cases of contact dermatitis cannot be definitively diagnosed without a patch test. Physicians have avoided the use of patch testing for a variety of reasons, chief of these being inconvenience and inconsistency. The TRUE patch test (Pharmacia AB, Uppsala, Sweden) offers a test modality that circumvents these problems. Background information on the TRUE test is presented along with two studies demonstrating its efficacy.*

Patch testing is a dermatologic diagnostic procedure utilizing selecting allergens. It is often bypassed because some physicians feel that history alone is sufficient to determine the source of sensitivity. However, some authorities suggest that suspected cases of contact dermatitis cannot be definitively diagnosed without a patch test.<sup>1</sup>

Contact dermatitis accounts for 10% of patient visits to the dermatologist, with up to 50% of these cases being allergy associated.<sup>2</sup> Before appropriate management plans can be devised, a cause of the allergy must be determined. Patch testing is the only definitive method of establishing the causative agent of hypersensitivity. Fifty percent of positive patch tests can be predicted by patient history.<sup>3</sup>

Calnan reports that physicians are reluctant to use extensive patch testing for four reasons: physician time requirements, the number of patient visits required, the lack of suitable test materials, and the risk of complications.<sup>4</sup> The present patch tests are perceived to be inefficient and their accuracy questionable unless administered by a dermatolo-

gist trained in patch testing. The inconsistency of suitable test materials has also complicated the use of this technique.

The TRUE test (Pharmacia AB, Uppsala, Sweden), is a newly developed patch test system. The company claims that it is easy to apply, delivers a quantitative dose of allergan challenge, and offers a high degree of quality control because the test applied to the patient is quantitatively and qualitatively analyzed by the manufacturer.<sup>5</sup> It is currently under evaluation at several centers in the US. The TRUE test allergans are incorporated into hydrophilic gels which are printed on an impermeable backing or polyester and dried to a thin film. This coated sheet is then cut into 9x9 mm squares (test patches) that are mounted on a tape, covered with a protective sheet, and packaged in an airtight and light impermeable envelope. The surface distribution and quantity of allergan dosed can be accurately controlled. Once the patch is applied, perspiration hydrates the film to a gel. The gel, covered with plastic, will produce adequate contact to provide good skin permeation resulting in high allergan bioavailability.<sup>6</sup>

The TRUE test consists of two panels. The first panel includes 12 common allergans of the international standard test series. The second panel contains 11 other frequent allergans. The combination of these two panels cover the whole standard series of the North American Contact Dermatitis Group (except formaldehyde) and will detect approximately 80% of contact sensitization present in the population.<sup>7</sup>

To use, one opens the envelope of laminated foil, pulls out the tape strip, removes the protective backing, and applies the strip on the lateral aspects of the upper back. If this location is not available, the upper arm may also be used. The dose of allergan is crucial for standardization of results. The allergan should cover the area completely, but without extrusion. The TRUE test contains 4-1500 ug allergan per cm<sup>2</sup>.<sup>8</sup>

The lower portion of the test strip should be applied first

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\* Mr. is affiliated with the Pharmacy Department at Arkansas Children's Hospital in Little Rock.



using mild pressure. The remainder can then be applied using the fore finger to smooth out any air bubbles. Extra tape to secure the corners is generally not necessary and should be avoided. Ethanol washings may be of benefit to degrease the area, as extremely sebaceous skin is a common cause of adhesive loss. Ethanol should be allowed to evaporate completely to avoid irritation from tape or patch. Excessive exercise is best avoided during the test period.<sup>9</sup> After 48 hours, the test should be removed by the physician, nurse, or the patient. Evaluation should be performed 72 to 96 hours after application.<sup>10</sup>

Patients should be provided with an instruction sheet explaining what the test is, that it must be in place continuously for two days, and when to return for reading. Patients should be told that during the test period excessive scratching, rubbing, sweating, or exposure to sunlight should be avoided.<sup>11</sup>

Patch testing indicates sensitivity and a gross estimate of intensity of reaction to allergens. Evaluation should occur at 72 to 96 hours after application for two reasons: 1) immediate irritant reactions have subsided, and 2) reactions of slow allergens have fully developed.<sup>12,13</sup> Parameters in evaluating reactions include erythema, edema, fine structure, surface distribution, and the area involved.<sup>14</sup>

General toxic reactions and induction of allergy with patch testing rarely occur. There may be an aggravation of dermatitis or increased itching in some patients. The normal disappearance of the patch test reaction is one to two weeks.

Two recent studies published in *Contact Dermatitis* report the efficacy of the TRUE test when compared to the older Finn chamber method. Both were multicenter, multinational studies utilizing a controlled, non-blind, within patient design. The first study tested 698 patients with 12 allergens. These 12 allergens were applied to opposite sides of the back using the Finn chamber method on one side and the TRUE test method on the other. There were positive test reactions to all 12 allergens tested in the patient group. The agreement of positive reactions between the TRUE test and the Finn chamber method was 67%. Thirteen percent of all positive reactions were recorded only for the TRUE test and 20% only for the Finn chamber method. The frequency of questionable and irritant reactions was about 2% for both test methods.<sup>15</sup>

The second study evaluated Panel 2 of the TRUE test. Eight hundred eight patients were tested with 11 allergens and a negative control and compared to the same 11 allergens applied using the Finn chamber method. There were positive reactions to all 11 allergens tested in the patient group. The agreement of positive reactions between the two methods was 63%. Seventeen percent of positive reactions occurred only with the TRUE test and 20% only with the compared method. Irritant or questionable reactions occurred in only 1% of the patients tested.<sup>16</sup>

In conclusion, studies have shown the TRUE patch test to be accurate and safe. It is easy to handle, adheres to the skin well, and is generally accepted by patients.<sup>17</sup> Pharmacia

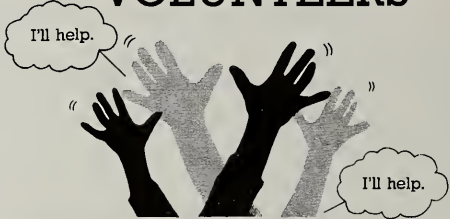
representatives expect the FDA to approve Panel 2 of the test sometime this winter, at which time the complete product will be marketed under the same name.

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For a complete list of references, contact the AMS office. ■

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# Survey Underscores Changing Attitudes of Young Physicians

Phillip Miller\*

**T**he majority of medical residents today receive over 50 offers of employment, expect to make at least \$100,000 or more their first year of practice, and would prefer an HMO or group setting to a solo setting, according to a survey conducted by Merritt, Hawkins & Associates, a national physician search firm based in Dallas, Texas.

The survey of 100 third-year medical residents indicates an continued shift away from traditional patterns of practice toward "9 to 5" medicine, Joseph Hawkins, chief executive officer of Merritt, Hawkins & Associates, said.

"The days when physicians put out a shingle and spent 70 to 80 hours a week performing hands-on care are long gone," Hawkins stated. "Physicians today expect different things from medical practice. They seek financial security and enough time away from work to enjoy life. Because demand for their services is so high, young physicians are in a position to obtain what they want."

Eighty-six percent of physicians surveyed had received at least 50 job offers, underscoring the current demand for physicians. Sixty-five percent of residents responded that they had received 100 or more job offers. Though many of these offers are from smaller, rural communities, 79% of residents surveyed would prefer to practice in mid- to large-sized communities. Only 5% of residents expressed a desire to practice in communities of 25,000 or less.

When asked which type of practice setting they would prefer, 69% of residents indicated either a group or HMO setting as a first choice. Only 8% of respondents preferred a solo setting, and only 5% preferred a partnership.

"Partnerships are where all the horror stories are generated," Hawkins observed. "Young physicians hear about partners who are domineering, whose spouses interfere or

who don't stick with agreements," Hawkins observed. "Few physicians today want to risk a bad professional marriage."

The marginal preference for solo settings highlights an even more disturbing trend, Hawkins said.

"The doctor used to be the ultimate example of the small entrepreneur whose practice was not a job, but a way of life," Hawkins stated. "Today, changing technology, bureaucratic hassles and malpractice worries have made solo practice seem like a trap to many young physicians. They prefer the support and security of HMOs or groups."

The trend away from entrepreneurial medicine also is reflected in the type of payment preferences that survey respondents revealed. Sixty percent of residents surveyed said they would prefer a salary as a form of compensation in their first practice. Twenty percent indicated a preference for an income guarantee. Only 15% preferred the standard fee for services form of payment by which physicians have traditionally been compensated.

"These payment preferences show the premium young physicians place on security and structure," Hawkins explained, "Because of convoluted third party payer schemes, physicians today would prefer the structure of a regular salary. Since young physicians carry an average debt of over \$40,000, they also seek the security of an income guarantee."

Hawkins contrasts these preferences to those of the old-style physician, who typically took out a bank loan to set up his or her first practice. None of the residents surveyed indicated a preference for a bank loan.

The survey also indicated that residents have a good idea of their value in the marketplace. Ninety-one percent of residents surveyed indicated that they expect to make at least \$75,000 to \$100,000 their first year in practice. Fifty-nine percent of residents surveyed expect to make \$100,000 or more.

Residents' financial expectations are not out of line with reality, according to Hawkins. Primary care physicians such as family practitioners and internal medicine practitioners

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\* Mr. Miller is with Triton Communications in Irving, Texas.



can expect to make guaranteed salaries of \$100,000-plus. Those in specialties such as cardiology or oncology can expect to make \$125,000 or more their first year, Hawkins said.

"This level of compensation may seem high, but, prorated over the length of their respective careers, most physicians make no more than lawyers or business executives," Hawkins observed.

Though the survey shows the further erosion of tradi-

tional medical practice, Hawkins remains upbeat about the quality and character of young physicians today.

"The essence of the physician-patient relationship — what's known as bedside manner — has evolved away from what it used to be for many reasons," Hawkins said. "Nevertheless, young physicians today are better trained and more motivated to provide quality care than they have ever been. As a potential patient, I feel secure about the care provided by young physicians today." ■

## Telephone Survey of 100 Medical Residents

1. How many practice opportunities have been presented to you by mail, telephone or in person, during the course of your residency?

25-50 .....	14%
50-75 .....	8%
75-100 .....	13%
100-200 .....	40%
Over 200 .....	25%

2. At what point in your training did you begin to seriously examine practice opportunities?

6 months or less before completing training .....	26%
1 year before completing training .....	50%
Over 1 year before completing training .....	24%

3. In which of the following settings would you most like to practice?

Solo .....	8%
Health Maintenance Organization .....	22%
Group .....	47%
Partnership .....	5%
Other (fellowship, locum tenens, academic setting, emergency, etc. ..	18%

4. If involved in a group practice, would you prefer a single specialty group, a multi-specialty group, or do you have no preference?

Single specialty .....	45%
Multi-specialty .....	40%
No preference .....	15%

5. Which of the following types of compensation would you most prefer at the start of your first professional position?

Fee or service .....	15%
Salary .....	60%
Income guarantee .....	20%
Bank loan .....	0%
Other .....	5%

6. What general level of compensation do you expect to achieve in your first year of professional practice?

\$50,000 - \$75,000 .....	9%
\$75,000 - \$100,000 .....	32%
\$100,000 - \$125,000 .....	17%
\$125,000 - \$150,000 .....	28%
\$150,000 - \$175,000 .....	5%
\$175,000 - \$200,000 .....	4%
\$200,000 - plus .....	5%

7. Are you planning to practice in the same general vicinity where you received your training or in proximity to your home town or your spouse's home town?

Yes .....	58%
No .....	42%

8. Based on population, in what size community would you most like to practice?

25,000 or less .....	5%
25,000-100,000 .....	16%
100,000 to 500,000 .....	37%
Over 500,000 .....	42%

9. On average, how many hours a week do you expect to work in your first year of practice?

30-40 hours .....	2%
40-50 hours .....	8%
50-60 hours .....	37%
60-70 hours .....	33%
70-80 hours .....	13%
Over 80 hours .....	7%

10. How long do you anticipate practicing at your first professional position?

1 year or less .....	7%
2 - 3 years .....	14%
3 - 5 years .....	12%
More than 5 years .....	67%



# Old Ledger Records Rural Doctor's Work



Charlotte Schexnayder

*This article originally appeared in the September 11, 1991 issue of the Dumas Clarion. In addition to being Editor in Chief and Publisher of the Dumas Clarion, Mrs. Schexnayder is a State Representative serving in her fourth term from District 80, which represents parts of Desha, Lincoln, and Jefferson counties. Charlotte Schexnayder was recently selected as the first female president of the 105 year old National Newspaper Association.*

**I**n old ledgers and account books exists a world of history.

Elbert Weaver of Dumas now has the account book of Dr. J.D. Watts, an early doctor in Dumas, and it has an especially meaning to Mr. Weaver. It records his birth.

Then, the doctor received \$35 for delivery of a baby. Office calls for baby checks were \$1.50 and \$2.50.

The doctor often recorded, in his financial ledger, kinds of treatment and the time of birth and sex of the baby.

Office calls, in the 20's and 30's, ranged from \$1 to \$3. Quinine for malaria was often listed as a medication, and aspirin was another drug recorded. Vaccinations for small-pox were \$1, before the day of the public health service. Typhoid vaccinations were also listed at \$1, and shots are frequently on the rolls of the ledger.

Barter was common. Entries show patients being given credit for such items as bringing in two bushels of peaches, mowing, breaking a garden, plowing orchard and hauling a load of wood. Four bushels of corn were accepted and were credited at \$1.75 per bushel. Another entry lists 20 bales of hay in barter.

One entry is simply entitled "buggy, \$45" - perhaps a long call into the countryside by buggy to deliver a baby? Night visits into the countryside apparently were billed at

\$12 but a widow was billed at \$6.

Country doctors of years past made many house calls, often in a leisurely kind of way which included visiting with the sick and his or her family. Buggies were frequently used as there were no hard surface roads reaching into rural areas. Sometimes a doctor would put his medicines and instruments into saddle bags and ride horseback to reach areas where muddy roads were tough for buggies.

The ailments ranged from malaria to accidents, but the "A" is even used. One page notes "Attention to abortion."

A notation is for extraction of a tooth at a cost of \$1. Showing the scope of his practice, Dr. Watts recorded treatment of a broken leg, eye ailments, ringworm, infected feet, and "surgical attention."

Cough syrup is a frequent notation in medication, but instances call for turpentine, iodine, Cuticura Ointment, liver tonic, Vicks, soda, carbolic acid and Black Draught.

In addition to malaria, the common ailments seemed to include colds and flu. Boils may have been a skin problem, because "lancing" is an entry.

Life insurance physicals were given for \$5 each. The good doctor also treated workers. One account was charged to the Iron Mountain Railroad, forerunner of the Missouri Railroad, "by bossman laying steel rails."

The good doctor was on call long hours, as the house visits attest. He may never have collected a large percentage of accounts, but his ledger is a record of true service to a community.

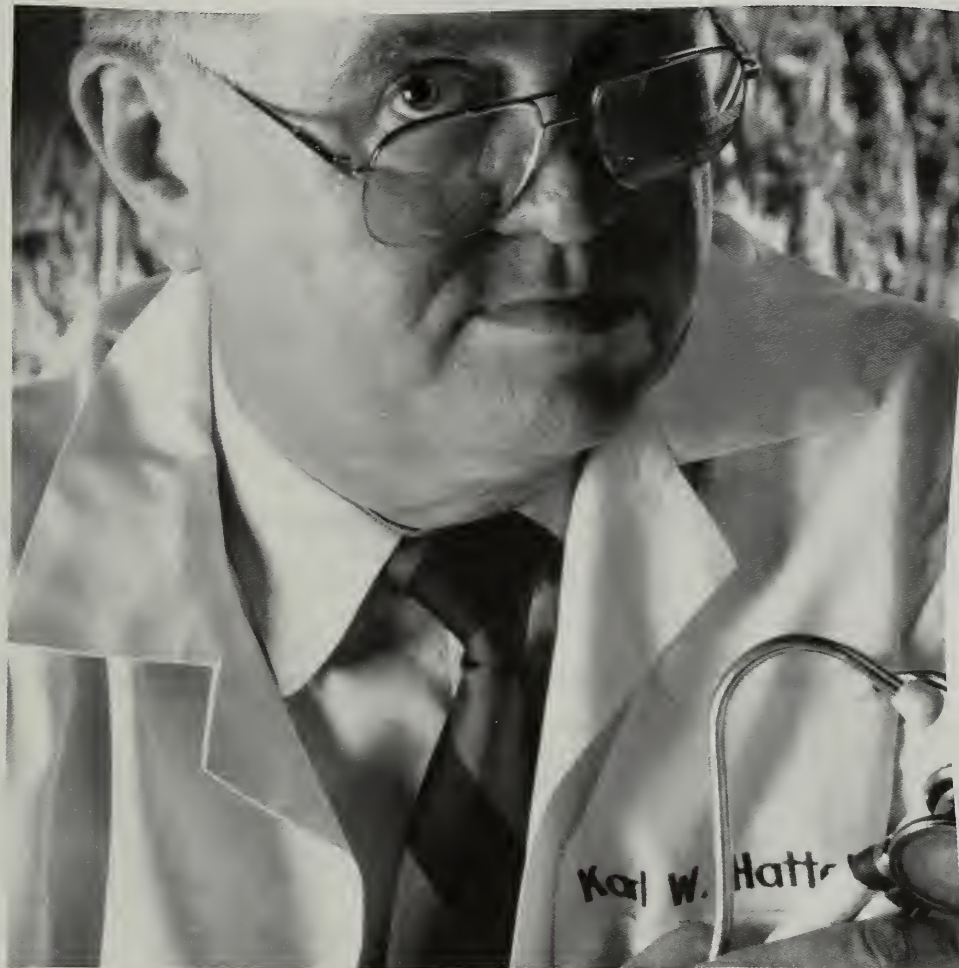
We didn't know Dr. Watts, but like other country doctors we knew, he was totally dedicated. He probably kept his own books along with doctoring. He was a counselor and friend, as well as doctor. He was an anchor in the community.

He was an era long gone, but nevertheless appreciated.





*"And I thought rehab was just a fancy name for Therapy."*



Dr. Karl Hatten doesn't work in rehabilitation, but he knows more about it than many so-called experts. He got his experience first-hand. As a nephrologist, he's spent more than 25 years helping patients deal with life-threatening diseases. But when he was hit by a stroke, he saw his own life hanging by a thread.

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confused by all the physical therapy programs that refer to themselves as rehab," he says. "My experience at MMRC taught me there's a big difference.

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# AIDS in Arkansas

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AMS Committee on AIDS

Joseph M. Beck, M.D., Chairman  
Donald C. Fournier, M.D.\*

## The Florida HIV Dental Case

Recently, many publications have included reports on the HIV transmission by Florida dentist, David Acer. One of these recent publications reported information obtained from the dentist's staff, patients and office records.<sup>1</sup> When one combines this information with the Centers for Disease Control (CDC) investigations, several important facts have emerged that may help us understand the HIV transmission that occurred in this dentist's practice. Several individuals were interviewed from a medical and legal standpoint, including the dentist's own personal physician. Since the medical community has been faced with increasing pressure from the public to have all health care providers tested for HIV, familiarizing ourselves with this particular case will help us explain to the public that this is indeed a unique case, and not indicative of all health care providers. Many frightening facts were uncovered which are presented in this cited publication (ref.1). This publication should be mandatory reading for all persons involved in public health care issues and policies.

In mid 1990 when the first report of a possible transmission of HIV during a dental procedure appeared, the immediate reaction in the lay public was that of panic.<sup>2</sup> Since that time, transmission has been confirmed by appropriate laboratory studies and other patients have been identified, currently resulting in at least five patients who are felt to have been infected from this one dentist.<sup>3,4</sup> The truly unfortunate circumstances involved in Kimberly Bergalis' case has touched the nation, as was observed in her recent emotional address to Congress. Her obvious bitterness towards the health care community as depicted in the recent article in *Newsweek* is understood. But, who is really to blame? Is it the federal, state, or local health officials and governing bodies?

Published information now indicates that Dr. Acer was

truly homosexual/bisexual and he admitted to 100-150 sexual partners during a 10 year period. It appears that he also treated sexual partners in his practice that may have not been listed as "official" patients. Review of his office records thus could not determine exactly how many HIV positive patients he truly treated in his office. He admitted to possibly ten HIV positive patients in his practice, but there is evidence that there may have more. There is concern that there could have been transmission from some of these HIV positive patients to other patients that he treated. This concern is based on interviews with his office staff, who reported that many times he may not have followed proper infection control procedures. In fact, he did not wear gloves routinely until approximately 1987, after he found that he had been infected with HIV. Even after that time, there are indications that he may not have followed appropriate guidelines with every single patient.

Certainly, had HIV testing been mandatory and had Dr. Acer been tested prior to Ms. Bergalis' visit for her first tooth extractions, and had she known that information, she may have elected not to be treated by Dr. Acer, and subsequently may not have been infected. Obviously, this is all speculative, but for Ms. Bergalis, the fact remains that she is dying from AIDS. Did she truly receive her HIV infection from Dr. Acer himself, or was it through his poor infection control techniques where he may have infected her from his instruments having been contaminated from other HIV patients with the same strain as Dr. Acer's HIV infection? Apparently, Dr. Acer had an unusual habit of placing syringes used for local anesthetic injections on a counter and not in an area designated for contaminated instruments. This brings up the possibility that a syringe used on a HIV infected patient could have been mistakenly used for a clean syringe on subsequent patients. This practice, combined with evidence obtained in the investigations indicating he did not properly sterilize instruments, and even reused disposable instruments, suggests that there could have been patient to patient transmis-

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\* Dr. Fournier is an allergy and immunology specialist in private practice in Texarkana, Texas. He is a member of the AMS Committee on AIDS.



sion. Even if this were indeed the circumstances, Dr. Acer is still the person on which one must place the blame, since he was ultimately responsible for all activity that transpired in his practice.

Infection control consultants were asked about certain practices that were common in Dr. Acer's office, and their determination is that contaminated instruments may have caused transmission of HIV, but that the evidence suggests that it was blood to blood transfer from Dr. Acer to the patients themselves. Still, upon interviewing his staff, evidence accumulates that improper sterilization had occurred, even after he had been diagnosed as having HIV infection. In fact, one staff member mentioned that Dr. Acer on occasions would only wash gloves between patients and not actually change the gloves. Also, other staff members reported that Dr. Acer on occasions did dental hygiene examinations without actually wearing gloves. Even though all of his office staff did not feel that Dr. Acer intentionally infected anybody, one still wonders that his office practice may have been lacking in appropriate infection control policies. This may prove to be the most important issue, and not his HIV status.

Dr. Acer's medical records were reviewed and indicate that he initially sought medical care under the name David Johnson, Johnson being his middle name, but still an assumed name. It appears that he may have known about his HIV infection before 1987, and, at least in 1986, the physician felt that he had ARC (AIDS Related Complex.) He clearly did not use gloves in office procedures until after 1987. Dr. Acer reported to the CDC that he was "shocked" to find out he was infected in 1987, even though he had high risk behavior and evidence of HIV infection prior to that time. His office staff reports that he did improve his infection control standards after 1987, up until at least the time that he sold his practice in 1989. They all feel that he was indeed a good dentist and very caring to all of his patients, but still the problem remains that he did not adequately follow infection control guidelines in his practice. This was in spite of knowing that he was of high risk behavior initially, and subsequently, infected.

To date, no other cases of patients having been infected with HIV from a health care provider have been reported. It has been well publicized that HIV infected surgeons have performed numerous surgical procedures without infecting one patient. A summary of HIV positive health care providers who performed invasive procedures is found in a recent CDC publication, in which four physicians and one dentist are documented to not have been responsible for any HIV transmission in their procedures.<sup>5</sup> In one investigation, 616 patients were tested for HIV, and only one patient was found to be positive, who was a known intravenous drug user. It was felt that this patient may have obtained his HIV infection from his high risk behavior. This same publication outlines the recommendations for preventing transmission of HIV and hepatitis B to patients during invasive procedures. These exposure-prone procedures are to be identified by local

organizations or institutions at which the procedures are performed. Ultimately, the general guideline is that all health care workers should adhere to universal precautions, appropriate use of hand washing and protective barriers, and adequate care in the use and disposal of needles and sharp instruments. It is further recommended that all health care providers who perform invasive procedures should know their HIV status. They then recommended that these individuals, if positive, should identify this status to prospective patients prior to the invasive procedure.

In retrospect, one could say that if these recommendations and guidelines had been followed in Dr. Acer's practice, HIV transmission to the five infected patients would have been prevented. One certainly wishes that this would have been the outcome, but still the real problem at hand is not that Dr. Acer needed to have the guidelines and recommendations from the CDC enforced into his practice, but that he should have voluntarily followed more appropriate office practices with his known high risk behavior and obvious infection. Dr. Acer did notify his patients on August 30, 1990, but at that time, it was too late for at least five patients, and perhaps even more with time.

Surely, one hopes that the public will not view this horrible nightmare as being representative of what may happen in dentist practices or physicians practices in the future with HIV infection, hepatitis B infection, or for that matter any injection. The circumstances in this case are unique, but the lesson learned is obvious. Common sense and good judgement were ignored until it was too late. Obviously, infection control guidelines have been available for decades and the concept of universal precautions is not a recent development in the practices of medicine or dentistry. The facts in this case must be emphasized to the public as we encounter more and more scenarios where HIV disease will impact upon medicine and health care workers.

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2. CDC. Possible Transmission of Human Immunodeficiency Virus to a Patient During an Invasive Procedure. MMWR 1990; 39:489-93.
3. CDC. Update: Transmission of HIV Infection During an Invasive Dental Procedure - Florida. MMWR 1991; 40:21-27, 33.
4. CDC. Update: Transmission of HIV Infection During Invasive Dental Procedures - Florida. MMWR 1991; 40:377-81.
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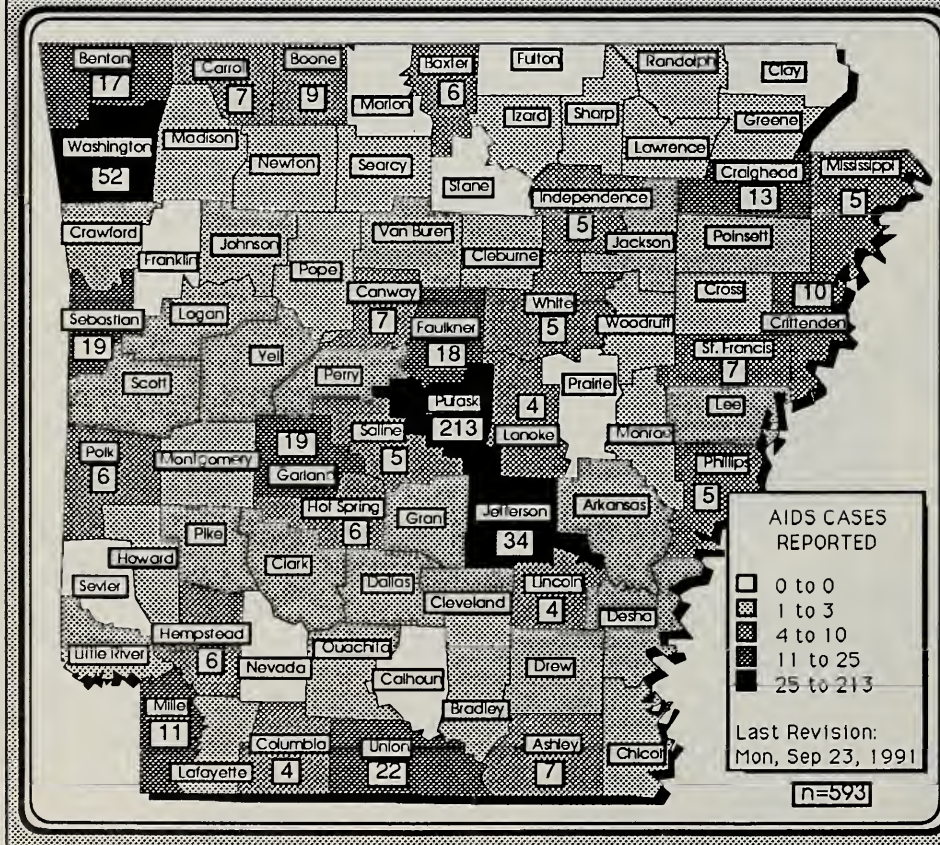
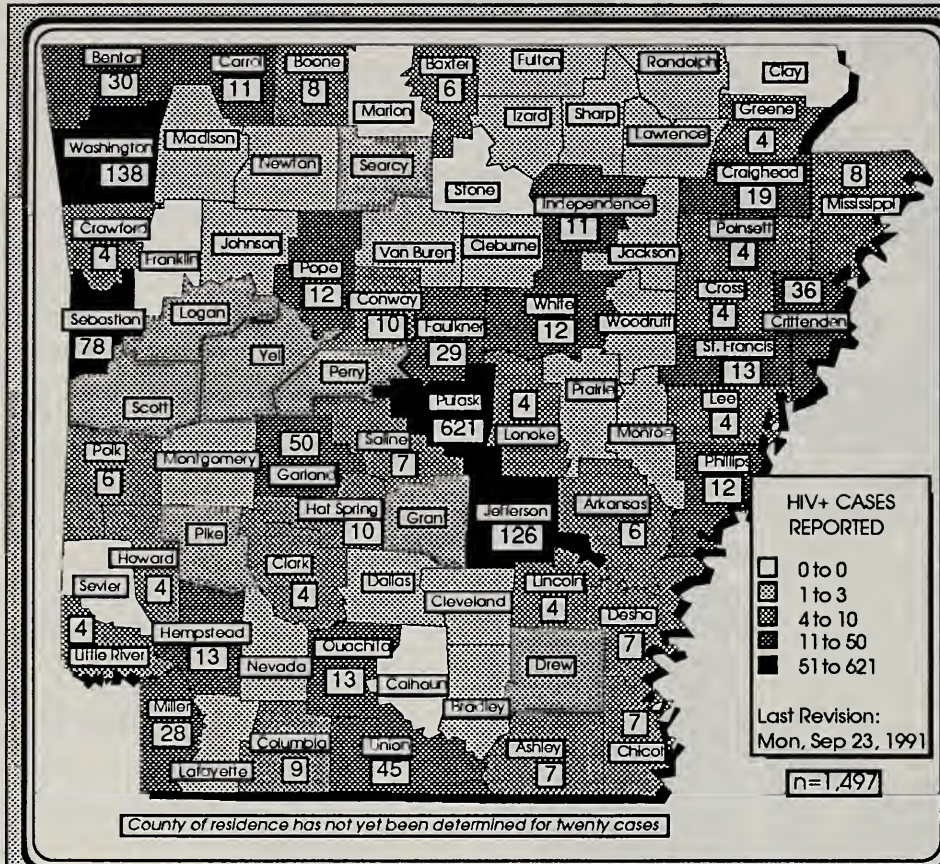
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# Arkansas HIV/AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who Is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of: Nursing Homes, Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

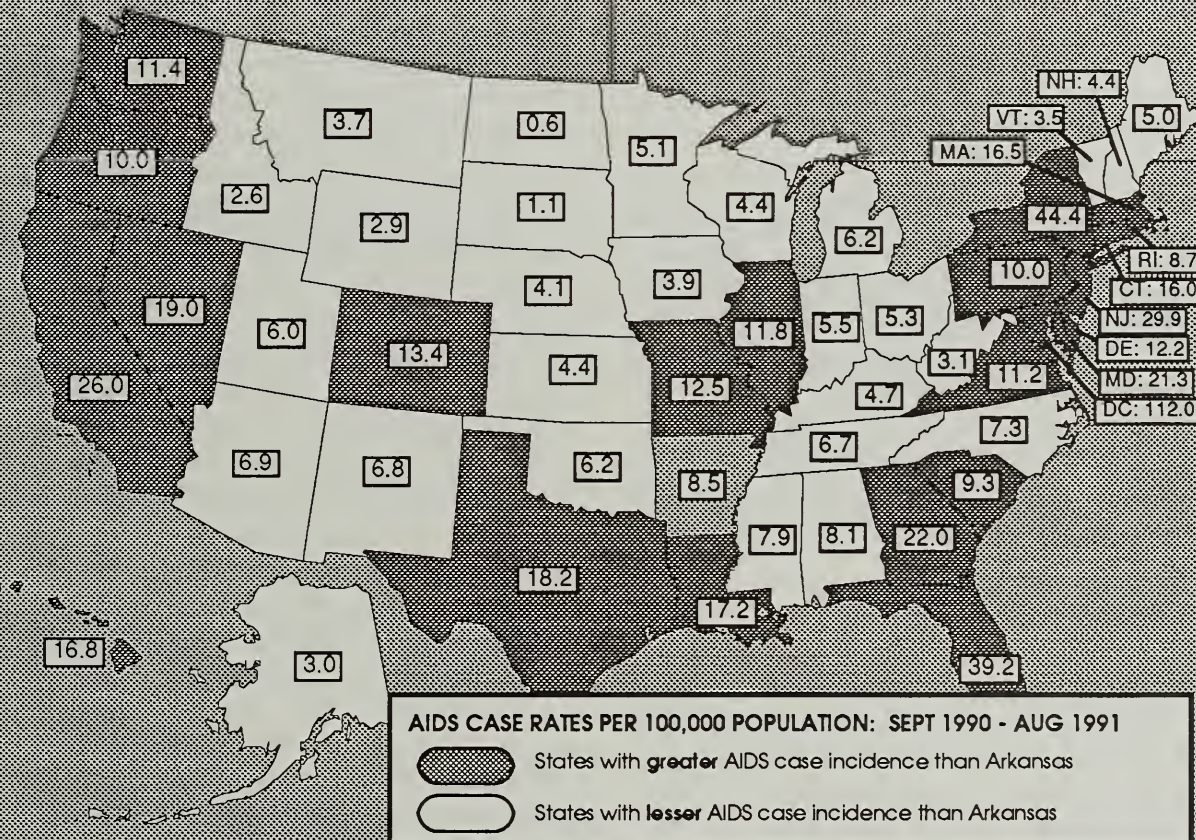
Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# Arkansas AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: SEP '90 - AUG '91	200	Reported: SEP '90 - AUG '91	44,714
Rates per 100,000 population: SEP'90 - AUG'91	8.5	Rates per 100,000 population: SEP'90 - AUG'91	17.5
Cumulative Reports: 1983 - SEP '91	593	Cumulative Reports: 1980 - AUG '91	191,601
Adult	579	Adult	188,348
Pediatric	14	Pediatric	3,253
Deaths: 1983 - SEP '91	332	Deaths: 1980 - AUG '91	122,905
Adult	326	Adult	121,196
Pediatric	6	Pediatric	1,709
Mortality Rate	56.0%	Mortality Rate	64.1%



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Gay or Bisexual Men	62.2%	Gay or Bisexual Men	57.8%
Heterosexual IV Drug Users	11.3%	Heterosexual IV Drug Users	21.9%
Gay or Bisexual Men who used IV Drugs	9.6%	Gay or Bisexual Men who used IV Drugs	6.4%
Heterosexual contact with person at risk	5.1%	Heterosexual contact with person at risk	5.6%
Transfusion with blood products	4.6%	Transfusion with blood products	2.3%
Perinatal	1.9%	Perinatal	1.4%
Hemophilia	2.0%	Hemophilia	0.9%
Risk unknown at this time	3.4%	Risk unknown at this time	3.7%



# Failure to Diagnose Myocardial Infarction

Cindy Conkle, RN, BA, ARM\*

**M**yocardial Infarction (MI) patients often do not have typical cardiac symptoms or underlying diseases. Approximately half of the deaths that occur due to myocardial infarction occur in a hospital. Most MI patients experience denial and seek medical attention from an emergency department only as a last resort. These factors make MI the most commonly misdiagnosed disease.

According to The St. Paul Companies' *Physicians and Surgeons Update 1991*, 104 failure to diagnose myocardial infarction claims were reported in 1989-1990 with an average cost of \$132,752 per claim.

## Case History

An elderly man was admitted to a hospital emergency room. He was unable to walk, had tremors, complained of dizziness, general malaise, "pain all over" and had been drinking for several days.

The emergency room physician contacted the patient's attending physician. After several discussions, the physicians sent the patient home by ambulance to "sleep it off." No lab work, physical, history or x-rays were completed in the hospital. The discharge diagnosis was *alcohol withdrawal*. Several hours later the patient died from a myocardial infarction.

"Willful and wanton gross negligence...The medical

care providers failed to act without a degree of skill...The care and treatment was the proximate cause of the patient's demise...Acts of the nurses and physicians contributed to the death of the patient."

These harsh allegations were made against the hospital, attending physician, the emergency room physician and nurse two years later.

During the trial, the main witnesses for the plaintiff were an expert witness and the patient's wife. The expert witness held that, "If the emergency room physician had completed an adequate physical exam, the patient would not have died." The wife testified that her husband's symptoms were: weakness, inability to walk without support, pain around the jaw, nausea, vomiting and sweating.

It also was revealed that the attending and emergency physicians disagreed on the treatment of the patient. The emergency physician felt the patient should have been admitted for observation. The plaintiff's attorney argued that the emergency room physician should have overruled the attending physician or followed the hospital's chain of command to admit the patient.

The attending physician's office records were subpoenaed and brought to the trial. The records showed a history of obesity, alcohol abuse and high blood pressure for which no medication had been prescribed.

In spite of the plaintiff's case, the jury brought in a verdict for the defense because of the vague symptoms that were masked by the patient's inebriation.

Coronary artery disease is a leading cause of death in the United States. In 1987, coronary disease caused 514,000 deaths and approximately 750,000 patients were admitted to

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\* Ms. Conkle is health care manager with The St. Paul Fire and Marine Insurance Company.



hospitals with acute myocardial infarction. In addition, there are about seven million patients with diagnosed coronary disease in this country and many more with clinically silent coronary atherosclerosis.<sup>1</sup>

As this case history shows, diagnosing coronary artery disease in the elderly patient often is challenging. The elderly may present with more non-specific symptoms than younger patients, such as retrosternal chest pain or absence of pain. In the emergency department setting, a thorough history and physical should be completed on elderly patients to rule out underlying coronary artery disease.

One study showed that a complete and careful history can be instrumental in diagnosing 92.7 percent of patients with coronary artery disease.<sup>2</sup> In another study, failure to take and record an adequate medical history and physical exam was strongly associated with failure to diagnose MI claims in the study group. In no case was a complete chest pain history quoted on patients even when the presenting complaint was non-traumatic chest pain.<sup>3</sup> This suggests that a standardized data collection system should be used. (e.g., the American College of Emergency Physicians' Quickform).

Perhaps a detailed history and thorough physical would have prompted the emergency room physician to do further tests and an EKG. No one knows if this would have saved the patient's life, but the completeness of the medical record, appropriate testing and appropriate treatment may have prevented both the death of this patient and the claim.

## References

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2. Goldman L, et al. Prospective multicenter validation of an algorithm to predict myocardial infarction in emergency room patients with chest pain. *Clinical Research*, 1986;34:365A.
3. Fastow JS, et al. Litigation against the emergency department physician, common features in cases of missed myocardial infarction. *Ann Emerg Med*, October 1989; 18(10):1029-1034.
4. Califf, Robert M, MD, presentation on Treatment and Prognosis of Acute Myocardial Infarction, 1991.
5. Lee, Thomas H, M.D., et. al. Ruling out acute myocardial infarction: A prospective multicenter validation of a 12-hour strategy for patients at low risk. *NEngl J Med*, May 1991, Vol. 324, No. 18.
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## Risk Management Tips

As these studies suggest, a systematic approach to diagnosing MI and following these risk management tips in the emergency department may prevent claims.

- Follow the American College of Emergency Physicians' *Clinical Policy for Management of Adult Patients Presenting with a Chief Complaint of Chest Pain, with No History of Trauma*. (A "Quickform" is available from the American College of Emergency Physicians.)
- Complete a detailed history and physical on all elderly patients to rule out underlying coronary artery disease. This should include any past history for risk factors, associated symptoms and a detailed history of the patient's pain. Also, patients with diabetes mellitus are more susceptible to "silent" MI.
- Rule out acute or impending myocardial infarction in all patients presenting with chest pain prior to the discharge of the patient from the emergency department.
- Recognize that the patient may be in a state of denial and will have a tendency to down play his or her symptoms.
- Do appropriate lab, x-ray and EKG.
- Interpret the EKG immediately. These should then be interpreted again by a cardiologist or physician credentialed to interpret EKGs.
- Obtain the results of critical diagnostic lab work prior to the discharge of the patient.
- Remember that substance abuse may mask symptoms of myocardial infarction.
- Examine carefully all new systolic murmurs and new heart and lung sounds.
- Document carefully the detailed history, physical exam and rationale for your diagnosis.



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## BAXTER COUNTY

**Neis, Paul R.**, Otorhinolaryngology, Mountain Home. Born, October 29, 1956, Lawrence, KS. Medical education, University of Kansas, Kansas City, 1982. Internship/residency, University of Kansas, 1988. Board certified. Practice experience, 3 years.

## POPE COUNTY

**Hass, Farrell D.**, Anesthesiology, Russellville. Born, November 19, 1959, McCall, Idaho. Medical education, UAMS, 1987. Internship/residency, UAMS, 1991.

## PULASKI COUNTY

**Bradford, James D.**, Ophthalmology, Little Rock. Born, April, 4, 1958, Oklahoma City, OK. Medical school, University of Oklahoma School of Medicine, Oklahoma City, 1984. Internship, Oklahoma Memorial, Presbyterian and Baptist Hospitals, Oklahoma City, 1985. Residency, Dean A. McGee Eye Institute/University of Oklahoma, Oklahoma City, 1988. Board certified.

**Brineman, John R.**, Pathology, Little Rock. Born, October 14, 1955, Tokyo, Japan. Medical education, Eastern Virginia Medical School, Norfolk, VA, 1980. Board certified.

**Davis, Brett C.**, Gastroenterology/Geriatrics, Little Rock. Born, December 17, 1956, Monticello. Medical education, UAMS, 1984. Internship/residency, University Hospital, 1986. Board certified.

**Gist, Charles C.**, Psychiatry, Little Rock. Born, July 19, 1961, Helena. Medical education, UAMS, 1986. Internship, UAMS, 1989. Residency, Los Angeles County/University of Southern California, 1991.

**King William D.**, Family Medicine, Little Rock. Born, September 1, 1959, Opelika, AL. Medical Education, LSU School of Medicine, 1982. Internship/residency, Medical University of South Carolina, Charleston, 1991.

**Klein Jr., F.F. Morris**, Anesthesiology, Little Rock. Born December 31, 1940, Sedalia, MO. Medical education, University of Missouri, Columbia, 1965. Internship, US Naval Hospital, Bethesda, MD, 1966. Residency, US Naval Hospital, San Diego, CA, 1969. Practice experience, 21 years. Board certified.

## WASHINGTON COUNTY

**Harris, Paul L.**, Anesthesiology, Fayetteville. Born March 23, 1955, Rogers. Medical education, UAMS, 1985. Internship/residency, UAMS, 1989. Practice experience, 1 year. Board certified.

## MEMBERS-AT-LARGE

### *Bentonville*

**McKenzie, James M.**, Orthopedic Surgery. Born, November 11, 1959, Little Rock. Medical education, UAMS, 1986. Internship/residency, UAMS, 1991.

### *Blytheville*

**Towns II, Myron B.**, General Pathology. Born, December 18, 1943, Greensboro, NC. Medical education, Meharry Medical College, Nashville, TN, 1978. Internship/residency, George W. Hubbard Hospital of Meharry Medical College, 1983. Practice experience, 6 years. Board eligible.

### *Clinton*

**Reddy, Krishna K.**, Internal Medicine. Born, December 1, 1948. Medical education, Gandhi Medical College, Bashaerbach Hyderabad AP India, 1973. Internship, Elyria Memorial Hospital, 1978; Jersey Medical Center, 1979; Grace NW Hospital-Wayne State University, 1981. Practice experience, 10 years.

### *DeQueen*

**Robert, Magdalene S.**, Pediatrics. Born, January 31, 1942, Grenada, WI. Medical education, College of Medicine, Newark, NJ, 1979. Internship, College Hospital and Childrens Hospital, NJ, 1981. Residency, Harlem Hospital, NY and Perth Amboy, NJ, 1983. Practice experience, 8 years.

### *El Dorado*

**Mason, Richard H.** Born, July 22, 1959, Melbourne, FL. Medical education, Would University (Universidad Munidal), Santo Domingo, Dominican Republic, 1988. Internship/residency, AHEC, El Dorado, 1991. Board eligible.

### *Fayetteville*

**Grear, Danna F.**, Radiology. Born, May 31, 1959, Rolla, MO. Medical education, University of Texas Medical Branch, Galveston, 1985. Internship/residency, University of Texas Medical Branch, Galveston, 1989. Board certified. Practice experience, 2 years.

**Grear, Tim W.**, Pediatrics. Born April 20, 1954, San Antonio, TX. Medical education, University of Texas Medical Branch, Galveston, 1984. Internship, Dartmouth-Hitchcock Medical Center, Hanover, NH, 1985. Residency, University of Texas Medical Branch, Galveston,



1987. Board certified. Practice experience, 4 years.

**Morse, Michael W.**, Neurology. Born, January 12, 1951, Atchison, KS. Medical education, Tulane Medical School, New Orleans, LA, 1977. Internship, Baylor University Medical Center, Dallas, TX, 1978. Residency, University of Texas Health Science Center, Dallas, 1981. Board certified. Practice experience, 5 years.

**Mullis, Ronald J.**, General Surgery. Born, November 16, 1959, Camp Springs, MD. Medical education, UAMS, 1986. Internship/residency, University Hospital, 1991.

**Raben, Susan L.**, Family Practice. Born, December 11, 1957, Kansas City, MO. Medical education, University of Kansas, Kansas City, 1984. Internship/residency, 1987. Board certified. Practice experience, 1 year.

#### *Fort Smith*

**Best, Timothy R.**, Neurology. Born, November 24, 1959, Little Rock. Medical education, UAMS, 1986. Internship/residency, Tulane Affiliated Hospitals, New Orleans, LA. Board eligible.

**Bise, Roger N.**, Plastic Surgery. Born, November 30, 1953, Butler, MO. Medical education, University of Kansas, 1983. Internship/residency, University of Kansas. Board eligible. Practice experience, 2 years.

**Humphreys, James D.**, Family Practice. Born, April 2, 1956, Dumas. Medical education, UAMS, 1988. Internship/residency, AHEC, Fort Smith, 1991.

**Jones, Greg T.**, Orthopedic Surgery. Born, September 17, 1960, Tahlequah, OK. Medical education, University of Oklahoma College of Medicine, 1985. Internship/residency, Barnes Hospital/Washington University, St. Louis, 1990.

**Lavery, John P.**, Internal Medicine. Born, November 10, 1955, Philadelphia, PA. Medical education, Universidad Automoma de Guadalajara, Mexico, 1982. Internship/residency, St. Agnes Hospital, Baltimore, MD, 1987. Board certified.

**Mosley, Myra C.**, Anesthesiology. Born, October 10, 1960, Sulphur, LA. Medical education, Tulane Medical School, New Orleans, LA, 1986. Internship/residency, Charity of New Orleans. Board eligible.

**Schroeder, Cygnet A.**, Physical Medicine & Rehabilitation. Born, October 10, 1954, Des Moines, Iowa. Medical education, College of Osteopathic Medicine & Surgery, 1979. Internship, Des Moines General Hospital. Residency, University of Kansas Medical Center, 1989. Board certified. Practice experience, 2 years.

**St. Clair, Kevin L.**, Dermatology. Born, July 30, 1961, Bowie, TX. Medical education, University of Texas Medical School, Houston, 1987. Internship/residency, University of Texas Medical Branch, Galveston, 1991.

#### *Hot Springs*

**Astle, Nancy J.**, Dermatology. Born, December 24, 1959, Edmonton, Alberta, Canada. Medical education, University of Alberta. Internship, Montreal General

Hospital, 1984. Residency, University of Michigan, 1987. Board certified. Practice experience, 3 years.

**Cunningham, Mark A.**, Anesthesiology. Born, February 10, 1945, Dayton, OH. Medical education, Vanderbilt University, Nashville, TN, 1970. Internship, Naval Hospital, Jacksonville, FL, 1971. Residency, University of North Carolina, Chapel Hill, 1977. Board certified. Practice experience, 14 years.

**Hale, Kevin D.**, Family Practice. Born, March 6, 1961, Bad Kreuznach, West Germany. Medical experience, UAMS, 1987. Internship/residency, AHEC, Pine Bluff, 1990. Board certified. Practice experience, 1 year.

**Olive Jr., Robert J.**, Orthopaedics. Born, January 29, 1955, Magnolia. Medical education, UAMS, 1983. Internship/residency, University of Kansas, Wichita, 1990. Practice experience, 1 year.

#### *Jonesboro*

**Meeks, Connie A.**, Family Medicine. Born, June, 8, 1953, Orange, TX. Medical education, University of Texas Health Science Center, San Antonio, 1986. Internship/residency, AHEC, Jonesboro, 1989. Board certified. Practice experience, 2 years.

#### *Little Rock*

**Archer, Robert L.**, Neurology. Born, April 2, 1956, El Dorado. Medical education, UAMS, 1982. Internship/residency, UAMS, 1986. Board certified. Practice experience, 5 years.

**Jasin, Hugo E.**, Rheumatology. Born, January 22, 1933, Buenos Aires, Argentina. Medical education, University School of Medicine, Buenos Aires, Argentina, 1956. Internship, Charles Wilson Memorial Hospital, Johnson City, NY, 1958. Residency, New York University, Goldwater Memorial Hospital, NY, 1959; University of Texas Southwestern Medical School, Parkland Memorial Hospital, Dallas, 1961. Board certified. Practice experience, 26 years.

**Karlson, Karl H.**, Pediatric Pulmonology. Born, May 26, 1946, Plainfield, NJ. Medical education, Tulane Medical School, New Orleans, 1972. Internship/residency, Charity Hospital, New Orleans, 1974. Board certified. Practice experience, 14 years.

**Mizell, Philip L.**, Psychiatry. Born, September 29, 1953, Aurora, CO. Medical education, UAMS, 1978. Internship/residency, UAMS, 1982. Board certified. Practice experience, 9 years.

**Schulz, Eldon G.**, Pediatrics. Born, May 10, 1954, Parkston, SD. Medical education, University of South Dakota School of Medicine, Vermillion, SD, 1980. Internship/residency, University of California, San Diego, 1983. Board certified. Practice experience, 6 years.

#### *Pine Bluff*

**Curry, Janet F.**, Internal Medicine. Born, September 26, 1955, Pine Bluff. Medical education, UAMS, 1983.



Internship/residency, Waterbury Hospital, CT, 1986.  
Board certified. Practice experience, 5 years.

#### *Searcy*

**Moore, Donald J.**, Pediatrics. Born, January 15, 1962, Camden. Medical education, UAMS, 1988. Internship, Childrens Hospital of Oklahoma, Oklahoma City, 1989. Residency, Arkansas Childrens Hospital, 1991. Board eligible.

#### *Springdale*

**Draughon, Edwin S.**, Child Psychiatry. Born, August 15, 1955, Miami, OK. Medical education, UAMS, 1985. Internship/residency, West Virginia University, Charleston, 1990.

**Wood, Russell H.**, Thoracic Oral Cardiovascular Surgery. Born, March 21, 1957, Tulsa, OK. Medical education, UAMS, 1983. Internship/residency, UAMS, 1990. Board certified. Practice experience, 1 year.

#### *Texarkana, TX*

**Strickland, Glen F.**, General & Vascular Surgery. Born, January 7, 1958, Columbia, SC. Medical education, UAMS, 1984. Internship/residency, University of South Carolina School of Medicine, 1990.

## RESIDENTS

**Harrison, Lonnie E.**, Cardiology, Little Rock. Born November 8, 1950, Rockford, IL. Medical education, UAMS, 1988. Internship/residency, UAMS.

**Ivy, Donald E.**, Anesthesiology, Little Rock. Born, March 19, 1962, Pocahontas. Medical education, UAMS, 1990. Internship, AHEC-NW, Fayetteville. Residency, UAMS.

**Klasson, Stephen C.**, Orthopaedic Surgery, Little Rock. Born October 26, 1960, Mesa, AZ. Medical education, Vanderbilt University School of Medicine, Nashville, TN, 1987. Internship/residency, UAMS.

**McElroy, Kellye C.**, Ophthalmology, Little Rock. Born March 20, 1961, Little Rock. Medical education, UAMS, 1987. Internship/residency, UAMS.

**Rahman, Holly E.**, Pediatrics, Little Rock. Born July 7, 1966. Medical education, UAMS, 1991. Residency, UAMS.

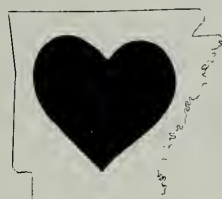
**Rahman, Salim**, Neurosurgery, Little Rock. Born May 13, 1960, Afghanistan. Medical education, UAMS, 1985. Internship/residency, UAMS.

## MEDICAL STUDENTS

Calvert, Harold M.

Osmon, Stephen B.

Yancey, Jennifer L.



### University Cardiothoracic Surgery

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# AMS Newsmakers

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**Dr. James D. Armstrong**, a family physician from Ashdown, has been elected chairman of the board of directors for the Arkansas Foundation for Medical Care (AFMC). He was the first elected to the board of AFMC in 1983 and served as secretary of the board from 1989 to 1991.

**Dr. Robert Dunn**, a general surgeon from Nashville, was elected vice president of the Howard County Unit of the American Cancer Society.

**Dr. Gary Edwards**, of Fort Smith, was elected president of the Arkansas Osteopathic Medical Association at their 6th Annual Convention.

**Dr. Bob Gosser**, a pediatrician from North Little Rock, has been appointed chief of medical affairs at Baptist Memorial Medical Center.

**Dr. John W. Joyce**, a radiologist from Little Rock, was named a fellow of the American College of Radiology at their Annual Meeting.

**Dr. Jerry Mann**, a family physician from Little Rock, is joining the faculty of the Department of Family and Community Medicine of the University of Arkansas for Medical Sciences, College of Medicine.

**Dr. Hampton Roy**, an ophthalmologist from Little Rock, was recently elected to the board of the American College of Eye Surgeons.

**Dr. Lander Smith**, a family physician from Conway, has been named a director of the Arkansas Academy of Family Physicians.

**Dr. Oba B. White**, a family physician from Little Rock, was honored for his long years of service to the community and to the medical profession by the Arkansas Medical Society, Arkansas Dental Association, and the Arkansas Pharmaceutical Association.

Dr. White is the oldest practicing physician in Pulaski County, having recently observed his 90th birthday.



*Dr. Fred Nagel and his wife, Lisa, vacationing in Cancun, Mexico. They won their trip at the AMS 1991 Annual Convention. It was given away as the grand prize drawing by Tours and Travel of Russellville.*

## Grand Prize Winners Enjoy A Grand Vacation

Dr. Fred Nagel and his wife, Lisa, won the physician grand prize drawing at the 115th Annual Session of the Arkansas Medical Society. The prize, a 4 day/3 night vacation in a five-star hotel for two to Cancun, Mexico, was donated by Tours and Travel of Russellville.

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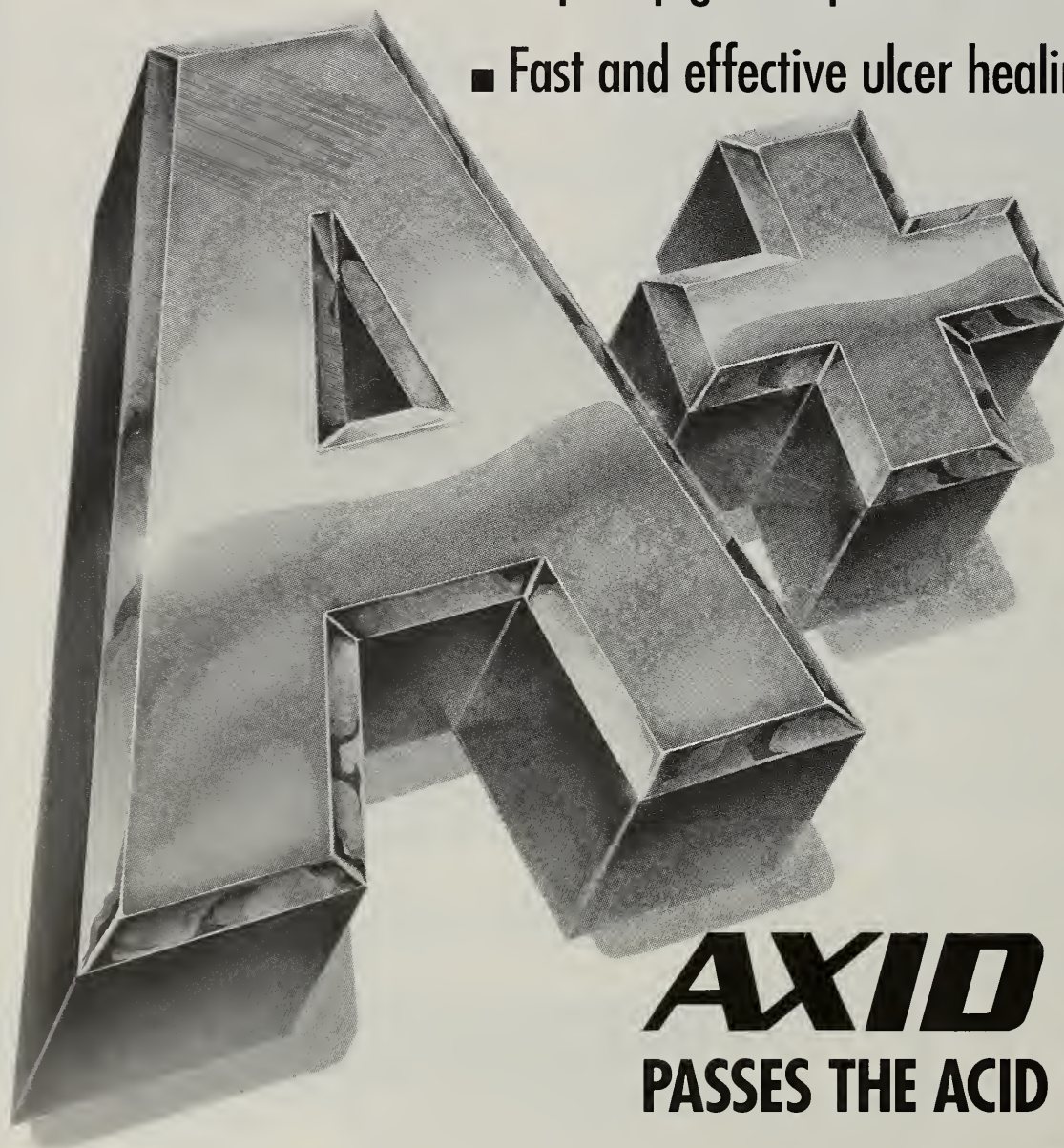


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has the right answers

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\*Most patients experience pain relief with the first dose.  
See adjacent page for references and brief summary  
of prescribing information.

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## AXID® (nizatidine capsules)

**Brief Summary:** Consult the package insert for complete prescribing information.  
**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

**Contraindications:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix\* may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 35 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.


**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP  
[091190]

### References

1. Data on file, Lilly Research Laboratories.
  2. Scand J Gastroenterol. 1987;22(suppl 136):61-70.
  3. Scand J Gastroenterol. 1987;22(suppl 136):47-55.
  4. Am J Gastroenterol. 1989;84:769-774.
- NZ-2943-B-149347

Additional information available to the profession on request.

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# In Memoriam

## Bascom P. Raney, M.D.

Dr. Bascom P. Raney, a retired family physician from Jonesboro, died Tuesday, September 10, 1991. He was 66.

Dr. Raney was a member of the Arkansas Medical Society. He served as a counselor for 12 years and was a member of the Physicians' Health Committee. He was appointed to the Arkansas State Medical Board in 1973. Dr. Raney was recently honored by the city of Jonesboro for his 37 years of service with a day in his honor - "Raney Day."

Survivors are his wife, Katherine Raney; three sons, Neal Raney of Little Rock, Sloan Raney of Solon, Iowa, and Lance Raney of Jay, FL; a stepson, Craig Seymour of Oklahoma City; a daughter, Sara Howell of Jonesboro; a stepdaughter, Kathy Stewart of Edmond, OK; and three step-grandchildren.

## Mrs. Gloria White

Mrs. Gloria White, of Fort Smith, died Tuesday, September 10, 1991. She was 55.

Survivors are her husband, Dr. J. Earle White; two daughters, Lisa Bell of Evansville, IN, and Julie Dinius of Redding, CA; and a brother, Daniel Meyer of New Jersey.

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# Medicine in the News

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## Health Care Access Foundation Update

As of September 1991, the Arkansas Health Care Access Foundation has provided free medical services to 3,134 medically indigent persons.

The program has 1,468 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## Applications Available for Rural Physician Incentive Program

The Arkansas Department of Health's Office of Rural Health and Primary Care is now accepting applications for physicians interested in financial assistance under the Rural Physician Incentive Program, Act 360 of 1991. This program is designed to attract and retain physicians in rural Arkansas communities. To qualify, a physician must establish a practice in a community of 8,000 or less, or establish a practice in a community that is in an area designated by the U.S. Department of Health and Human Services as medically underserved.

Applications are competitive, and will be ranked by areas of highest need. Physicians accepted into the program will receive financial assistance grants starting at \$6,000 for the first completed year of service, and increasing by \$2,000 per year for the next four years. The total award offered under this program is equal to \$50,000 per physician. Physicians interested in applying should contact Dale Roark at the Office of Rural Health and Primary Care at (501) 661-2083 by phone or by mailing their name and address to: Dale Roark, Arkansas Department of Health, Office of Rural Health and Primary Care, 4815 W. Markham St., Slot 22, Little Rock, AR 72205.

## Resolution Urges Uniform CME Standards

The AMA Council on Medical Education is working on a proposal to develop uniform nationwide standards for continuing medical education hours. The American Academy of Family Physicians, American College of Obstetricians and Gynecologists and California Medical Association currently have their own definitions. CME hours can be used to meet educational requirements to qualify for medical society membership, reappointment to a hospital medical staff or relicensure. At its September meeting, the council reviewed progress that had been

made toward developing uniform standards as envisioned in Resolution 102 (I-90).

## Award Requirement is Postponed

At its 1990 Interim Meeting, the AMA's House of Delegates changed the requirements for the Physician's Recognition Award. The house voted that Category 2 continuing medical education credits would be mandatory. The purpose of the change, according to the AMA Division of Continuing Medical Education, was to encourage physicians to be more self-directed in their continuing education. Category 2 includes consultation with peers and medical experts, use of electronic databases in patient care, self-assessment activities, small group discussions, journal clubs, medical writing, and conferences and seminars that for some reason do not meet the criteria for Category 1. After the house action, a number of physicians notified the AMA that they had not maintained records of Category 2 education. Others reported that they could not find Category 2 education on short notice. At the 1991 Annual Meeting, the Hawaii Medical Association and the Kansas Medical Society entered resolutions against the requirement. As a result, the house has called on the Board of Trustees to study the question and report back at next year's Annual Meeting. Therefore, the Category 2 requirement is being postponed, the division announce. If the requirement is eventually sustained, it could be phased in beginning January 1, 1993.

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# Radiological Case of the Month

Gary W. Barone, M.D.  
Beverley L. Ketel, M.D.  
David L. Harshfield, M.D.  
Steven R. Nokes, M.D.

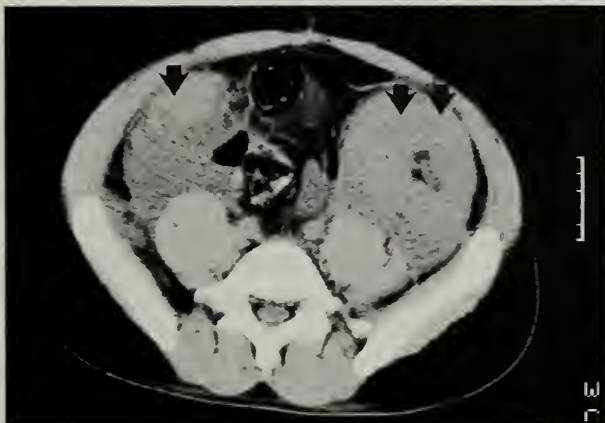
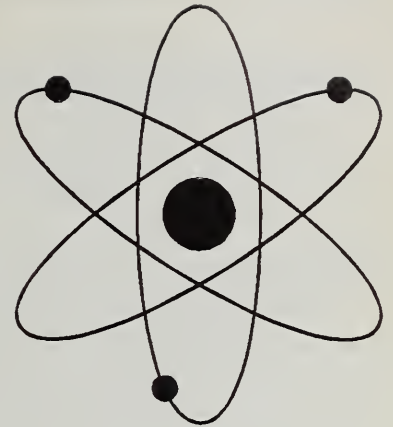


Figure 1. Enlarged renal transplant (double arrow). Distal tip of pancreatic transplant (arrow) (Total scale 5 cm).

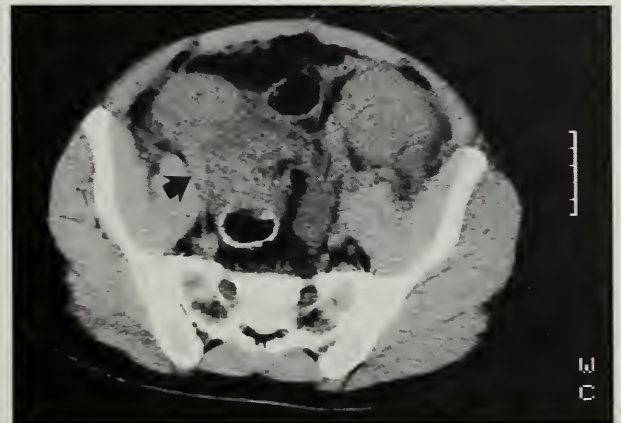


Figure 2. Pancreatic transplant with phlegmon (arrow) (Total scale 5 cm).

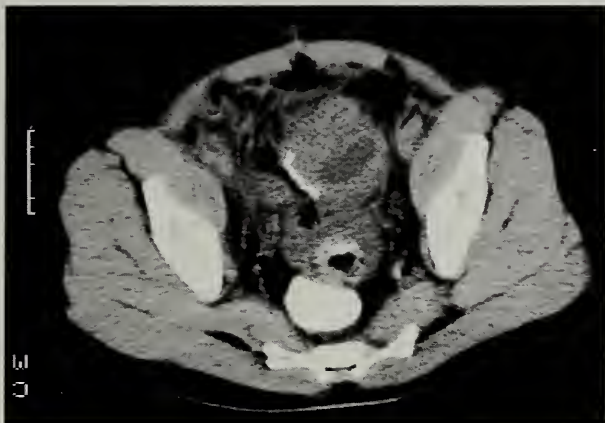


Figure 3. Pancreatic head and duodenal segment w/staples (arrow) (Total scale 5 cm).

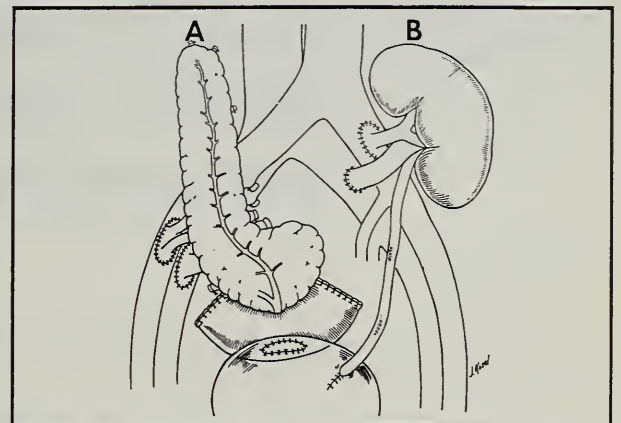


Figure 4. Combined pancreas (A) and renal (B) transplant (used with permission).

## History:

A 33-year-old male was admitted with a one day history of acute onset of severe right lower quadrant abdominal pain with associated nausea, vomiting, and fevers. His past medical and surgical history was pertinent for being approximately one month after a successful combined cadaveric renal pancreas transplant for end-stage renal disease secondary to juvenile onset diabetes mellitus. His laboratory tests revealed a markedly elevated serum amylase of 700 units/liter (less than 150 units/liter being normal) with associated elevated white blood cell count of 17,000/cmm and a mildly elevated serum creatinine 2.5 mg/dl. An abdominal/pelvic CT scan was obtained to evaluate the possibility of a peripancreatic abscess versus acute cellular rejection.



---

# Combined Pancreas and Renal Transplant with Acute Cellular Rejection

---

## Radiographic Findings:

Several cross sections of this patient's abdominal/pelvic CT scan are seen in Figures 1-3 with arrows identifying appropriate structures. Bladder, rectal, oral, and intravenous contrast is needed in order to fully evaluate the transplanted organs located within the pelvis. This CT scan revealed an enlarged transplanted kidney along with a peripancreatic phlegmon and pancreatic parenchymal inhomogeneity consistent with transplant pancreatitis. This has the overall appearance of acute cellular rejection. Because of this CT scan along with a histologic confirmation of rejection from a renal biopsy, this patient was treated for acute transplant organ rejection.

## Discussion:

With the introduction of both cyclosporine A (Sandimmune: Sandoz) and improved surgical techniques, whole organ pancreas transplantation has become clinically successful.<sup>1</sup> However, isolated and sequential pancreas transplants (i.e. following a previous renal transplant) continue to have an overall poor survival rate mainly because of the inability to monitor isolated pancreatic rejection. Most pancreatic transplants are presently done in combination with a cadaveric renal transplant from the same donor since rejection will occur in both organs in 80-90% of the time with the kidney being easily biopsied for histologic evidence of rejection. Recipient selection, therefore, usually includes Type I juvenile onset diabetics who suffer from end-stage renal disease requiring some method of dialysis. The two year survival in this group for the transplant patient is approximately 90%, for the renal transplant of 90%, and for the pancreatic transplant of 80%.

As seen in Figure 4, the pancreas is usually anastomosed intraperitoneally to the right iliac vessels with the pancreatic exocrine secretions being drained into the bladder. The renal transplant is placed on the left iliac vessels and positioned in a retroperitoneal pocket behind the left colon. Abdominal and pelvic CT scans with the appropriate contrast agents resulting in complete gastrointestinal and bladder opacification have been previously reported to be extremely useful in identifying complications following a combined kidney/pancreas transplant.<sup>2,4</sup> These findings may include bladder leaks (duodenum or ureter), pelvic abscesses or peripancreatic/perinephric collections, and phlegmons. In addition as shown in this patient, a CT scan can be used as an adjunct to the identification of acute rejection. However, a CT scan is not usually necessary as part of the evaluation for rejection in these patients because most rejection episodes present without major abdominal findings and with only mildly elevated serum amylase and serum creatinine. It should be noted that serum glucose control usually remains normal in these patients even during acute rejection, and if abnormal this usually signifies severe destruction of the organ.

## References

1. Sutherland D, Dunn D, Goetz F, et al. A 10-year experience with 290 pancreas transplants at a single institution. *Ann Surg* 1989; 210:274-88.
2. Longley D, Dunn D, Gruessner R, et al. Detection of pancreatic fluid and urine leakage after pancreas transplantation: value of CT and cystography. *AJR* 1990; 155:991-1000.
3. Letourneau J, Maile C, Sutherland D, et al. Ultrasound and computed tomography in the evaluation of pancreatic transplantation. *Radiol Clin NA* 1987; 25:345-55.
4. Moulton J, Munda R, Weiss M, et al. Pancreatic transplants: CT with clinical and pathologic correlation. *Radiology* 1989; 172:21-6.

*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Gary W. Barone, M.D., is assistant professor of Vascular & Transplant Surgery with the Division of Transplantation, Department of Surgery at the University of Arkansas for Medical Sciences in Little Rock.*

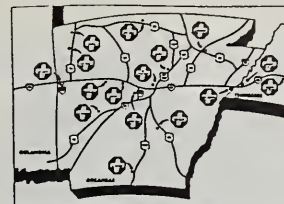
*Contributor: Beverley L. Ketel, M.D., is with the Division of Transplantation, Department of Surgery at the University of Arkansas for Medical Sciences in Little Rock.*





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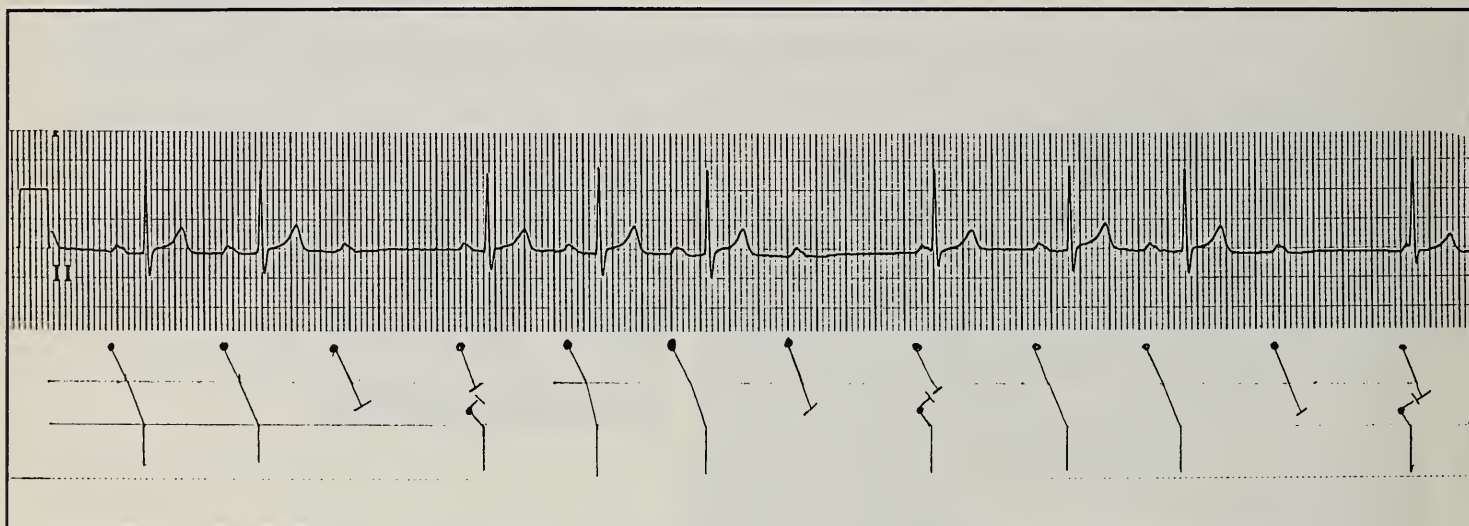




# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

This is an interesting record where all is not as it appears.



## DISCUSSION:

Superficially, this record appears to be a straight forward example of second degree AV block (Type I or Wenckebach). The basic rhythm is sinus rhythm with sinus arrhythmia. QRS complexes appear in groups of two with three P waves and progressive prolongation of PR intervals, suggesting Wenckebach AV block with 3:2 conduction. However, there are two important anomalies: the R-R intervals enclosing the pause are constant and the PR intervals following the pause. In fact, the PR interval following the second pause is approximately 0.8-1.10 seconds in duration, suggesting that the P wave is not conducted. This observation, along with the constant RR intervals closing the pause suggest that the QRS complexes following the pause arise from junctional escapes. The combination of the junctional escape complexes and slowing of the sinus rate between the non-conducted P wave and the returning cycle result in the R-R interval enclosing the pause being **greater** than any two consecutive conducted QRS complexes. By contrast, typical Wenckebach periodicity requires that the R-R intervals enclosing the pause be **less** than and two consecutive conducted intervals. That Wenckebach periodicity is indeed the mechanism underlying the second degree AV block in this case is evidenced by the progressive PR prolongation in the conducted complexes. What do you think?



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# Things To Come

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## December 7

**8th Annual Clinical Update in Pulmonary Medicine.** Caesars Hotel, Atlantic City, NJ. Sponsored by the Department of Pulmonary Medicine, Deborah Heart and Lung Center of the Center for Bio-Medical Communication, Inc. Category 1 CME credits available. For more information, contact Robert Silver at (201) 385-8080.

## December 11

**Pediatric Transfusion Therapy Teleconference.** Sponsored by the American Association of Blood Banks. Fees: \$20.00, members; \$30.00 nonmembers. For more information, contact the AABB Department of Education at (703) 297-0522.

## January 24-25, 1992

**Transfusion Medicine 1992.** Arlington, Virginia and Los Angeles, CA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$190.00, members; \$240.00, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

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*November 13, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room. Sponsored by UAMS and presented by Jay Kincannon, M.D. Fee: \$5.85. Category I credits available.*

## **Pediatric Endocrinology**

*November 14, 12:00 noon, Sparks Regional Medical Center, 4th floor conference room. Sponsored by UAMS and presented by Stephen Kemp, M.D. Fee: \$5.85. Category I credits available.*

## **AHEC-Pine Bluff ACLS Course**

*November 18-21, Ashley Memorial Hospital, Crossett. Sponsored by UAMS College of Medicine and presented by Donald Miller, M.D. Fee: \$150.00. Category I credits available.*

## **The Seasonal Child**

*December 3, Arkansas Children's Hospital, 1st floor classroom (S120-121), Sturgis Building. Sponsored by Arkansas Children's Hospital. Fee: \$25. Category I credits available. For more information, call (501) 320-1248.*

## **8th Annual Conference on Perinatal Care**

*December 5-6, Excelsior Hotel, Little Rock. Sponsored by UAMS College of Medicine and presented by J. Gerald Quirk, M.D. Fees: range from \$185.00 to \$60.00. Category I credits available.*

## **ATLS Provider Course**

*December 7-8, UAMS Education Building. Sponsored by UAMS College of Medicine and presented by Drs. Barnes and Mabry. Fee: \$575.00. Category I credits available.*

## **Pediatric Gynecology**

*December 18, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room. Sponsored by UAMS and presented by Karen Kozlowski, M.D. Fee: \$5.85. Category I credits available.*

## **Arkansas Hand Club Annual Meeting**

*May 8-9, 1992, Gaston's White River Resort, Lakeview. For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058*

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.*

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC*

*Medical Grand Rounds, Fridays, 12:00 noon, VAMC*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium*

*Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457*

*Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom*

*Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium*

*Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom*

*Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom*

*Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided*

*Journal Club, Tuesdays, 12:00 noon, Dunkerton/AP&L room. Lunch provided*



*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Pathology classroom. Lunch provided  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon. Lunch provided  
*Sleep Disorders Case Conference*, every other Thursday, Video Production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon. Sandwich buffet served

## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., conference room 1  
*GI Conference*, 4th Friday, 12:00 noon, call BMC at 227-2672 for location  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room 3 times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Nervousurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours



*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## **FORT SMITH - AHEC**

*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville



*Interesting Case Conference*, 4th & 5th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

## **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st through 4th Friday, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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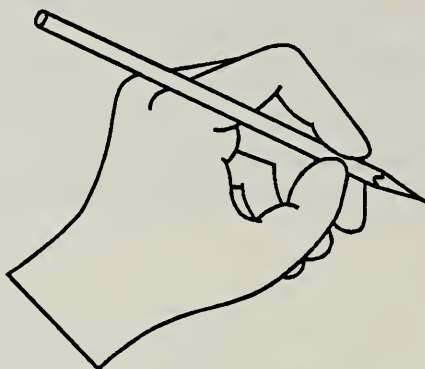


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*Advertising Agencies in italics*

American Physicians Insurance Exchange ....	inside front
Arkansas Express Claims .....	291
Arkansas Blue Cross & Blue Shield .....	270
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Central Arkansas Rehabilitation Hospital ....	back cover
<i>Fowler Martin &amp; Associates</i>	
ClaimNet, Inc. ....	278
Collom & Carney Clinic Association .....	286
Eli Lilly & Company .....	292/293
<i>Garrison, Jasper, Rose &amp; Company</i>	
Tommy Farrell Associates .....	278/297
<i>Thomas J. Farrell Agency</i>	
Freemyer Collection Systems .....	253
Medical Protective Company .....	273/299
<i>Ferguson Advertising, Inc.</i>	
Mediquik Walk-In Clinics .....	297
MED/PAC - Formcraft of Arkansas, Inc. ....	301
MEDX .....	286
Mississippi Methodist Rehab Center .....	277
<i>Maris, West &amp; Baker, Inc.</i>	
Orthopaedic Research & Education Foundation .....	293
Radiology Consultants .....	307
Rather, Beyer & Harper .....	269
St. Joseph's Regional Health Center .....	266
<i>Kirkpatrick &amp; Associates</i>	
State Volunteer Mutual Insurance Company .....	262
<i>The Maryland Group</i>	
Tanyard Springs .....	261
<i>A. Tim Irby Advertising, Inc.</i>	
U.S. Air Force .....	281
<i>Bozell, Inc.</i>	
University Cardiothoracic Surgery .....	289

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Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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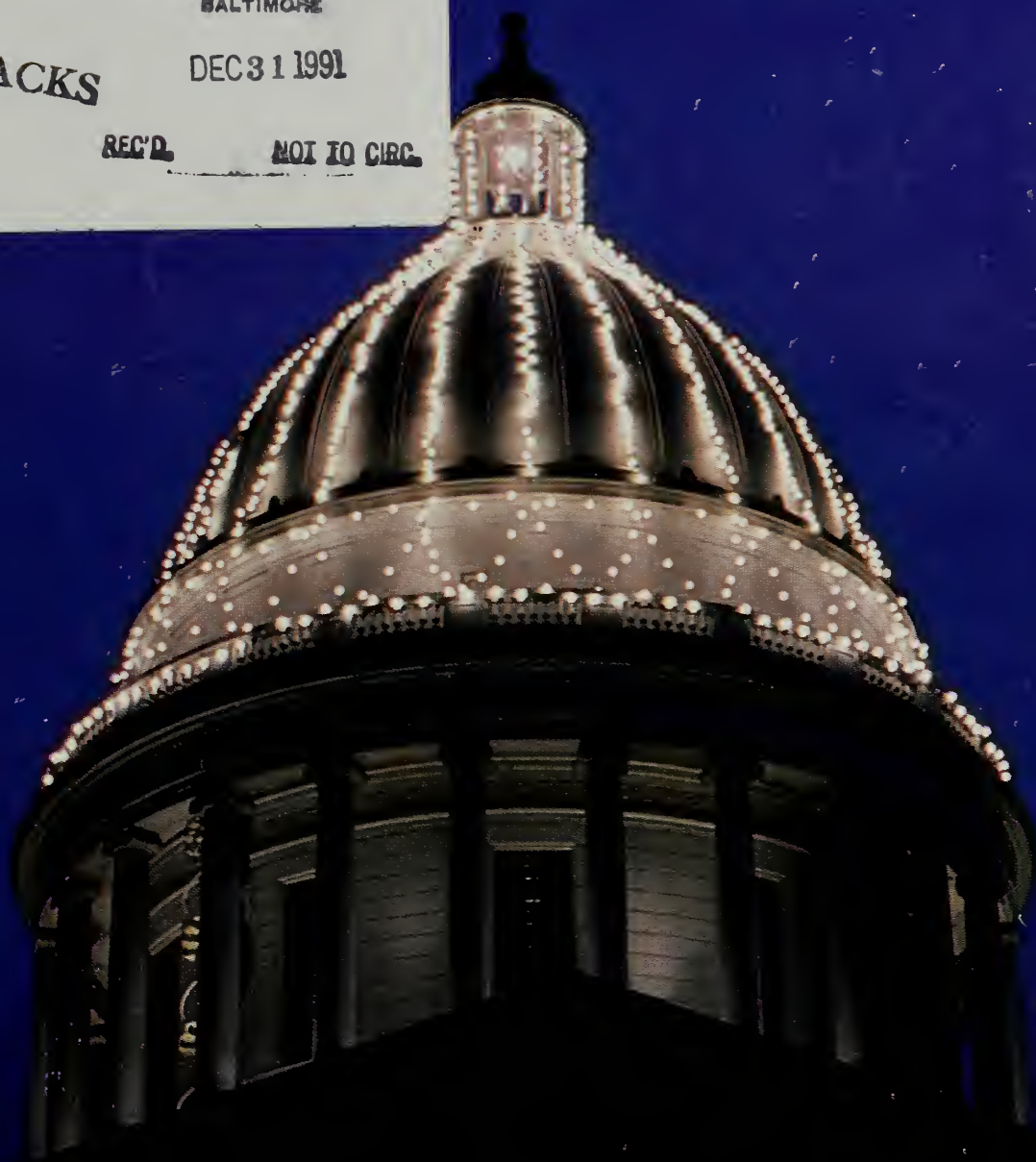
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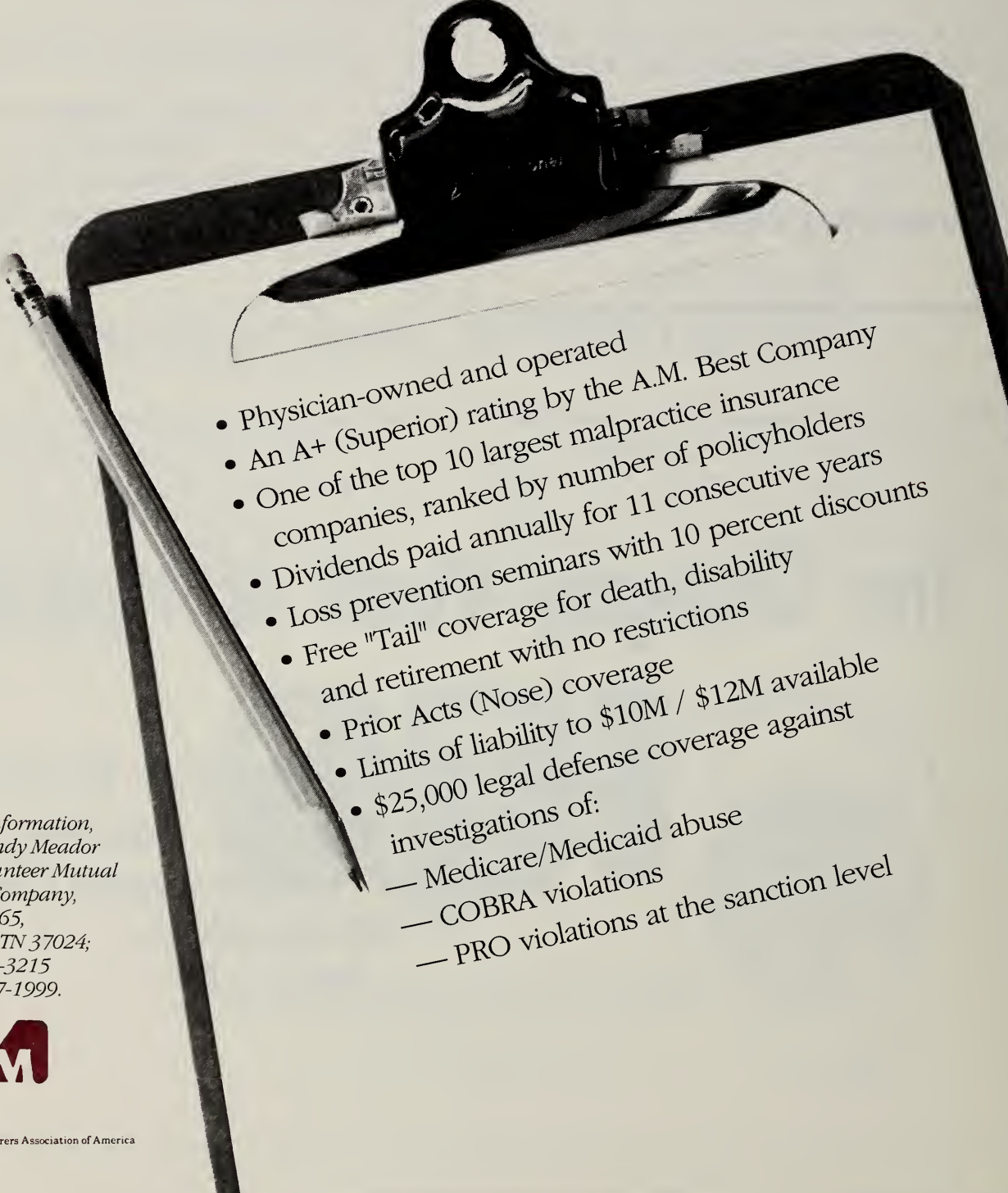
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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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## CONTENTS

### FEATURES

- |     |  |
|-----|--|
| 312 | <b>Substance Abuse and Pregnancy</b><br><i>Editorial</i><br>Sam Shultz, M.D.   |
| 315 | <b>The New CPT</b><br><b>Evaluation and Management Codes</b><br><i>Special Article</i><br>American Medical Association |

### DEPARTMENTS

- |     |                                       |
|-----|---------------------------------------|
| 344 | <b>New Members</b>                    |
| 346 | <b>AMS Newsmakers</b>                 |
| 348 | <b>In Memoriam</b>                    |
| 350 | <b>AIDS in Arkansas Statistics</b>    |
| 352 | <b>Medicine in the News</b>           |
| 353 | <b>Radiological Case of the Month</b> |
| 357 | <b>ECG of the Month</b>               |
| 356 | <b>Things to Come</b>                 |
| 358 | <b>Keeping Up</b>                     |

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# Substance Abuse and Pregnancy

Sam Shultz, M.D.

In 1977, I presented a seminar dealing with the number of neonates exposed to substance abuse (excluding alcohol) during pregnancy. It was necessary to review approximately two years worth of newborn records at the University of Arkansas for Medical Sciences Center to obtain 15-20 cases. Regrettably, this would not be the case today. It is estimated that approximately 1.2% of deliveries at University Hospital occur to mothers who have abused a substance - usually cocaine.

The problem of babies born to mothers who regularly use drugs is staggering. The Centers for Disease Control (CDC) and the National Institute on Drug Abuse (NIDA) provide us with the following statistics:

- 60% of women of childbearing age drink alcohol; 10% have more than two drinks per day - enough to cause fetal alcohol syndrome (FAS).
- 11% of new mothers use cocaine, marijuana, heroin, amphetamines, or methadone at some time during pregnancy.
- Discounting alcohol exposure, it is estimated that 40,000 to 375,000 babies have been exposed to an illicit substance antenatally.

The side effects of many of these substances are well known. Prematurity, low birth weight, CNS damage, withdrawal syndrome, and teratogenic malformations have been reported. Even though the risk of congenital malformations (excluding FAS) may be small, there seems to be no doubt that neurological and behavioral dysfunctions continue to be problematic as these children grow up.

The difficulty in proving a cause and effect relationship lies with several factors. Most women abusing drugs have little or no prenatal care, suffer from inadequate nutrition, have a poor self-image, perhaps come from a dysfunctional family, and depression. It is no surprise to the experienced clinician that these women are unable to cope with the stressors of a newborn, especially one who may have health problems.

Several barriers to treatment exist for the pregnant patient. There is a national shortage of programs to serve this sector of the population. Chavkin reports that 54% of programs in New York City categorically refused to serve pregnant addicts. Participation of the other 46% was limited. Tracy, et al, states that women participating in drug treatment programs risk having the service terminated when the pregnancy is discovered.

Another barrier is that traditional treatment programs are likely to be confrontational and punitive - inappropriate for patients with low self-worth. After the infant is delivered, few treatment programs have the capability to care for mothers and infants together.

It is generally agreed that substance abuse is symptomatic of underlying multifactorial problems. While as physicians, we may not be able to address all such problems in our patients who present with abuse, there are several actions we can take. We should encourage our elected officials to support treatment programs that would include the pregnant abuser. We should work with the social service agencies to expand protective services to this group of high-risk children and infants. Finally, physicians should take an active role in our professional societies' efforts to develop health care services for these women and children. Drug czars and "just say no" have not eradicated this problem. Let us try committed physician involvement.

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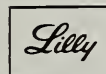
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# The New CPT Evaluation & Management Codes

## Introduction

The new CPT codes presented in this issue represent a major change in how physicians report their interactions with patients. The significance of these changes will be felt immediately on January 1, 1992 when Medicare will require use of the new codes.

As this issue of *The Journal of the Arkansas Medical Society* goes to print, AMS staff and representatives of the Medicare carrier are conducting a series of 13 workshops around the state. Through these workshops and this special issue of *The Journal*, we hope to educate and inform as many physicians as possible on the definitions and use of the new E/M codes.

## Background Information on the Development and Use of the New Evaluation and Management (E/M) Codes

Timely implementation of the new Medicare Payment Schedule (MPS) (required by section 6102(a) of the Omnibus Budget Reconciliation Act of 1988, as amended by the Omnibus Budget Reconciliation Act of 1990) required important revisions to the American Medical Association (AMA) Current Procedural Terminology (CPT).

Key among the important revisions are changes to the CPT codes for evaluation and management services (i.e. visit codes) now listed in the CPT 90000 series. These "visit" codes represent approximately 35% of the payments to physicians under the Medicare Part B program, and when combined with private health insurance plans affect the processing and payments for nearly one billion health insurance claims annually.

Recognizing the importance of this coding revision, the purpose of this discussion is to inform you as to the overall direction and structure of the coding changes that have been developed by the AMA's CPT Editorial Panel.

## Process

Nearly three years ago, the AMA's CPT Editorial Panel embarked on, and has now completed, a comprehensive visit coding revision process that has, at times, involved input or reactions from:

- The CPT Panel's Ad Hoc Committee on Visits and Levels of Service;
- The national medical specialty societies (both through direct testimony and through the societies' representatives on the CPT Advisory Committee);
- The Health Care Financing Administration (HCFA) and the Harvard University RBRVS research team;
- Representatives of the AMA's Councils on Medical Service and Legislation;
- Direct communications with hundreds of practicing physicians; and
- A special Consensus Panel convened jointly with the Physician Payment Review Commission (PPRC). This broad-based panel was particularly useful as its report generated a series of 21 focused recommendations, 19 of which have been accepted by the Editorial Panel for incorporation in the new visit coding system.

Overall, the Editorial Panel placed its primary emphasis on assuring the determination of the appropriate level of services will continue to be based on the



content of the services the physician provides to his/her patients. Descriptions of that content have been adjusted to accommodate accurate and equitable assignment of the resource-based relative values and the elimination of specialty payment differentials as mandated in the OBRA '89 legislation. Accordingly, time and other factors, will be included as "contributory" elements.

Although no coding or classification system can satisfy every physician's needs in every clinical situation, the Editorial Panel believes that the coding changes will make it easier for physicians, or their office staff, to select the proper CPT code; provide appropriate reporting mechanisms for prolonged patient/physician encounters; assure that physicians receive the correct payment for their evaluation and management services; facilitate communications with patients; reduce the need for medical necessity review which is associated with coding questions; and overall, reduce the carrier/physician/patient "hassles" that continue to be a significant problem for practicing physicians (e.g., automatic downcoding). Each physician used the proposed visit codes to code 25-30 clinical descriptions drafted by their specialty societies. Next, code sheets were tabulated to identify descriptions for which code assignment was difficult. These "problem" descriptions provided the basis for focus groups, in which physicians discussed advantages and disadvantages of the proposed codes.

## Field Study

The field study surveyed 64 physicians in each of 6 Medicare carrier areas in 4 states (New York, California, South Carolina, and Kentucky) who were to apply the proposed codes to actual patient encounters in their practices. These physicians assigned both a current CPT visit code and a proposed code to 40 consecutive office visits and up to 40 consultation and hospital visits. They also completed a brief questionnaire on their coding experience. Some physicians used a version of the new coding system that included information on the time involved in such visits. Others used a version without time information. Responses were received from 173 physicians.

The major purposes of the field study were to determine whether the new codes reduce current variation in coding patterns across carriers, to determine the effect that including time will have on these variations, to identify potential problems with use of the new codes, and to obtain structured physician comments and suggestions. The results of the summary questionnaire completed by field study respondents, as well as the lab study focus groups, provided clear evidence that the proposed CPT codes for visits and consultations were quite workable. They also provided

evidence that inclusion of time in descriptions may both aid and complicate coding decisions.

Formal statistical analyses were conducted for both the lab study and field study results. These data provide information on the reliability of the proposed codes and the degree to which time affects code choice.

## Reliability Study-Focus Group Results

There was considerable similarity in the points raised in all of the lab study focus groups across the five specialties. The focus groups were designed to identify important themes rather than formal consensus conclusions. Each point identified by the focus groups has been re-examined by the CPT Editorial Panel and many of these ideas have been incorporated into subsequent revisions of the codes.

## Reliability Study-Statistical Results

For each clinical description coded, about one-third of physicians coded a description that included a time chosen from the high end of a range supplied by the relevant specialty society. About one-third had a "low time" and the remaining third asked the physicians to supply a time. Each physician coded a mix of "high", "low", and "no" times. For purposes of statistical analysis, the codes chosen by physicians were converted to continuous variables by assigning to them the times used in the CPT proposal.

The following points summarize the major conclusions from the reliability study. The vast majority (86%) of clinical descriptions were considered of no (40%) or low (46%) difficulty in-coding; including time in the descriptors does not substantially improve coding reliability; the actual time required to provide a service neither dominates nor exerts a major influence on coding practices; the "typical times" used in the draft codes correspond well to the independent estimates of time by physicians; and overall reliability was moderately good and physicians were unlikely to vary by more than one level of service for the same clinical vignette.

## Field Study Questionnaire

Questions typically covered each of the three types of codes tested: office visits, consultations, and hospital visits. Given the study's emphasis on testing office visits, there were generally more responses for these visits than other categories. Responses for office visits were generally representative of the other categories. Because of small cell sizes and study design, the patterns of responses may not be representative of the attitudes of all physicians who will use this new coding system.

Nonetheless, these responses involve over 5,843



office visits provided by 173 physicians in over 20 specialties, 6 Medicare carrier areas, and 4 states. As a result, they provide a unique and invaluable source of information on how these proposed codes will fare in actual practice.

The major conclusions and associated evidence drawn from the field study questionnaire were the following: Physicians could use the new codes effectively to distinguish among clinical encounters; the new codes are workable and may improve on the current codes; and including time in the code aids coding but does not substantially improve coding reliability.

## Field Study-Statistical Results

Unfortunately, the study of the effects of the draft codes on differences among carrier areas was inconclusive because of low response rate. As discussed previously, however, the field study questionnaire on physician responses to the proposed codes provided valuable information.

## Conclusions

The results of the pilot study of the CPT Editorial Panel's proposed revisions to visit and consultation codes, provided substantial evidence that the new evaluation and management codes can be easily and reliably used by physicians. This conclusion reflects the ease with which physicians used the codes, focus group discussions, and questionnaire responses by physicians using these codes in their practices.

These studies suggested that both the benefits and the drawbacks of including explicit time information in code descriptors are less than either the opponents or the proponents of such a policy had imagined. In general, whether or not a time factor is included in the code, when choosing the appropriate code, physicians appeared to place a relatively low emphasis on the time associated with providing a service. Inclusion of time information may exert a slight positive influence on coding reliability and would be consistent with a payment system that uses information on typical time to assign relative values for these services.

Besides considering several hundred pieces of correspondence to ensure clinical appropriateness, the draft CPT evaluation and management codes underwent a tow-part pilot test jointly sponsored by the American Medical Association and the Health Care Financing Administration: a reliability study and a field study. The results of this pilot test were used by the CPT Editorial Panel to make any needed revisions in the new codes prior to their finalization. They were also used by HCFA in developing policy on the inclusion of time information in the new visits and consultation codes.

## Commonly Asked Questions About the E/M Codes

### 1. When will the new evaluation and management codes go into effect?

At the time this material was prepared, the effective date of use of the new evaluation and management codes for Medicare was January 1, 1992. The final notice of the rules is expected to be published in the Federal Register in November 1991; the effective date for Medicare will be published at that time.

### 2. Will there be a crosswalk established between the old levels of service codes and the new evaluation and management (E/M) codes?

There is no direct comparison or crosswalk between the previous levels of service and E/M codes. Neither HCFA nor the AMA supports a crosswalk. The new E/M codes are distinctly different from the previous levels of service codes. There are also specific new guidelines to follow to use the new E/M codes.

### 3. Will all third party payors accept these new codes? If so, when will they accept them?

The current level of service codes (90000-90699, 90750-90764) will be deleted from CPT 1992. These levels of service codes will not be maintained by the AMA. Each individual private carrier will need to determine if and when it will use the new E/M codes. You will need to check with your local private carriers concerning implementation dates. All Medicare carriers are mandated to use these new E/M codes.

### 4. What will the format of these new codes be? (i.e., numeric, alphanumeric.)

The new E/M codes in CPT 1992 will be all numeric (5 digits). They will be found in the 99000 series of codes.

There will be a new section of CPT entitled "Evaluation and Management." It will be found in the front of the 1992 CPT book where the current "Medicine" section is located. All codes in the current "Medicine" section that follow the current levels of service codes (e.g., infusion therapy, therapeutic or diagnostic injections, psychiatry) will be moved to the back of the CPT book. These codes will then numerically follow the pathology and labora-

*(continued on page 319)*



## Reliability Study

The reliability study brought together 107 physicians from five specialties (internal medicine, family practice, general surgery, pulmonology, and rheumatology), as well as 48 Medicare Carrier medical directors, to apply the proposed codes to a set of clinical descriptions and then to review the codes in focus groups.

The purpose of this study was to evaluate how reliably physicians coded consultations, office visits, and hospital visits. A major goal was to determine whether including time in the definition of visit codes improved reliability—that is, made it more likely that different physicians would assign the same code to a visit. For this reason, half of the physicians in this study used a draft coding system that included time in its definitions; the other half used a system that did not.

The two drafts were otherwise identical.

The results of these studies suggested several refinements to the new codes. First and foremost, they indicated the need for explicit guidelines for both physicians and payors on the manner in which inconsistent variations in the components of these codes (e.g., content of service, type of patient problem, typical time) should affect code selection.

In particular, it is essential that both physicians and payors understand the distinctly secondary role of time in code choice as well as those circumstances in which time should play an important role in choosing the appropriate code. Accordingly, the Editorial Panel has continued to place its primary emphasis on assuring that the determination of the appropriate level of service will continue to be based on the content of the services that the physician provides.

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## Definitions of Commonly Used Terms Associated with the Evaluation and Management Codes\*

Certain key words and phrases are used throughout the evaluation and management (E/M) section of CPT. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties. (They are presented in alphabetical order for ease in reference.)

**Counseling** - Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) option;
- risk factor reduction; and
- patient and family education.

**Established Patient** - An established patient is one who has received professional services from the physician within the past three years.

**Examination** - The levels of E/M services recognize four types of examination that are defined as follows:

- Problem Focused - an examination that is limited to the affected body area or organ system.
- Expanded Problem Focused - an examination of the affected body area or organ system and other symptomatic or related organ systems.
- Detailed - an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive - a complete single system specialty examination or a complete multi-system examination.

**History** - The levels of E/M services recognize four types of history that are defined as follows:

- Problem Focused - chief complaint; brief history of present illness or problem.
- Expanded Problem Focused - chief complaint; brief history of present illness; problem pertinent system review.
- Detailed - chief complaint; extended history of present illness; extended system review; pertinent past, family and/or social history.
- Comprehensive - chief complaint; extended history of present illness; complete system review; complete past, family and social history.

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\* These definitions are presented as a teaching tool. The user, when actually reporting the new codes, must refer to the complete set of guidelines which precede all of the new evaluation and management codes in CPT 1992 and the specific instructions in each category or subcategory.



**Levels of evaluation and Management Services** - The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services. The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M service may be used by all physicians.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of the presenting problem; and
- time.

The first three of these components (history, examination, and medical decision making) are considered the KEY components in selecting a level of E/M service.

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered contributory factors in the majority of encounters. Although the first two of these (counseling and coordination of care) are important E/M services, it is not required that these services be provided at every patient encounter. Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The nature of the presenting problem and selected examples of clinical situations are provided in some levels to assist the physician in determining the appropriate level of E/M service.

**Time is Discussed More Fully as a Separate Definition** - (See page 320)

**Medical Decision Making** - Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- the number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

tory code numbers. Several of the codes now in the medicine section (e.g., 90282, 90292) will be renumbered codes will remain the same; they will just be renumbered for the sake of continuity.)

5. Will the number of levels in the new E/M codes be the same as in the current levels of service code?

The number of levels in the new E/M codes will be the same for some types of services (e.g., office or other outpatient); however, in some sections there will be more levels (e.g., consultations); in other sections there will be less levels (e.g., home).

6. Will the descriptions be the same (i.e., brief, limited)?

The new E/M codes will not have the same descriptors as the current codes. The descriptors will contain terms that will be defined to provide clarity and to promote uniformity in the use and interpretation of the new codes.

7. On what components are these new codes based?

The E/M codes are based on the contribution of each of these components provided by the physician:

- \* history;
- \* examination;
- \* medical decision making;
- \* counseling;
- \* coordination of care;
- \* nature of presenting problem; and
- \* time.

8. How important then is time in selecting the appropriate code to report the physicians' services?

The inclusion of time in the definition of levels of E/M services has been implicit in prior editions of CPT. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians in selecting the most appropriate level of E/M service. The specific times expressed in the visit code descriptions are averages and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Although time is a contributing factor in defining the levels of the evaluation and management services, the content of the services provided is the determining factor when selecting an E/M code. In the case where counseling and/or coordination of care dominates (more than 50%) the face-to-face physician/patient encounter, then time is consid-

(continued on page 321)



## Medical Decision Making

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality
straightforward	minimal	minimal or none	minimal
low complexity	limited	limited	low
moderate complexity	multiple	moderate	moderate
high complexity	extensive	extensive	high

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in the table above must be met or exceeded.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M service unless their presence significantly increases the complexity of the medical decision making.

**Nature of Presenting Problem** - A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

- Minimal - a problem that may not require the presence of the physician, but service is provided under the physician's supervision.
- Self limited or minor - a problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter health status or has a good prognosis with management/compliance.
- Low severity - a problem where the risk of morbidity without treatment is low; there is little or no risk of mortality without treatment; full recovery without functional impairment is expected.
- Moderate severity - a problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis or increased probability of prolonged functional impairment.
- High severity - a problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment.

**New Patient** - a new patient is one who has not received any professional services from the physician within the past three years.

**Time** - The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of CPT. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians in selecting the most appropriate level of E/M service. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

The content of service is used to select the appropriate level of E/M service. In the case where counseling and/or coordination of care dominates (more than 50%) the face-to-face physician/patient encounter, then time is considered the key or controlling factor. The extent of counseling and/or coordination of care must be documented in the medical record.

### Recruiting Physicians

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Bentonville, AR 72712  
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## Instructions for Using the New Evaluation and Management Codes, Focusing on the Office or Other Outpatient Services Codes\*

1. Identify the category and subcategory of service. In this article, the category is "Office and other Outpatient Services." The subcategories in this section are: "New Patient" and "Established Patient."

**NOTE:** Levels of evaluation and management services are interchangeable among the different categories or subcategories of service. For example, the first level of E/M service in the subcategory of office or other outpatient visit, new patient, does not have the same definition as the first level of E/M service in the subcategory of office or other outpatient visit, established patient. (SEE 99202 - compared to 99212. Code 99202 requires three key components; code 99212 indicates two of three key components must be performed.) (i.e., subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by the type of service, place of services, and patient's status.)

2. Review the guidelines under the office or other outpatient services. These specific guidelines (as well as the general guidelines found in the front of CPT 1992 in the evaluation and management section) apply to these office or other outpatient services.
3. Review the level of E/M service descriptors and examples in the selected category or subcategory. (Look at your definitions list under Levels of E/M Services. The seven components are listed there.) (Remember that time is only considered the key or controlling factor where counseling and/or coordination of care dominates (more than 50%) the face-to-face physician/patient encounter.)

Note that for the first category of new patient office and other outpatients services (99201) requires that the three key components be present:

- a problem focused on history;
- a problem focused examination; and
- straightforward medical decision making.

\* These instructions are presented as a teaching tool. The user, when actually reporting the new codes, must refer to the general guidelines which precede all of the new evaluation and management codes in CPT 1992 and the specific instructions in each category or subcategory.

ered the key or controlling factor. The extent of counseling and/or coordination of care must be documented in the medical record.

### 9. What will the new codes look like?

The basic format of the new E/M codes follows:

- \* A unique code number is listed;
- \* The place or type of service is specified (e.g., office or other outpatient);
- \* The content of the service is defined (e.g., a problem focused history; a problem focused examination; straightforward medical decision making);
- \* The nature of the presenting problem(s) usually associated with a given level is described;
- \* The time typically required to provide the service is specified; and
- \* Examples of specific clinical situations are provided to assist the physician in selecting the correct code.

An example of one of the new E/M codes demonstrating this new format follows:

#### NEW PATIENT

- 99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- \* a problem focused history;
  - \* a problem focused examination; and
  - \* straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

#### Examples

##### *Internal Medicine:*

Office visit with an out-of-town visitor who needs a prescription refilled because she forgot her hay fever medication.

##### *Oral and Maxillofacial Surgery:*

Office visit to advise for or against the removal of wisdom teeth, 18 year old male referred by an orthodontist.

### 10. How will the new E/M codes be used?

The key to using the new codes is to read the general guidelines that will be located at the begin-

(continued on page 322)



ning of this new section of E/M codes. Then, you will also need to look at the specific guidelines in the category or subcategory of the E/M codes that corresponds to the place of service where the services were provided (e.g., inpatient hospital services, nursing facility services). The instructions will tell you how many of the elements for each component need to be met to report that code.

For example, the code used in the example (99201) in the previous question indicates that all three key components are required to report that code - (i.e., a problem focused history, a problem focused examination and straightforward decision making are all required).

There will be definitions contained in the general guidelines in the E/M section which will define what a problem focused history is, as well as what a problem focused examination and straightforward decision making are.

#### 11. What needs to be documented to qualify to report these new codes?

The medical record will need to indicate the physician performed the services being reported or that these services were performed under the direct supervision of the physician (i.e., in a problem focused history, there needs to be evidence in the patient's record of a chief complaint and brief history of the present illness or problem). The physician will also need to indicate in the record his/her examination of the affected body area or organ system. They type of medical decision making (i.e., the number of diagnoses or management options, the amount and/or complexity of data to be reviewed and risk of complications and/or morbidity or mortality) performed by the physician is included in each code selected. Although it is not easy to demonstrate in writing some of these decision, an audit of the patient's record should provide evidence of the amount or complexity of data. The risk of complications and/or morbidity or mortality is minimal. So to select a code with high complexity would be incorrect to report services related to an office visit with a diagnosis of the common cold in an otherwise health patient.

#### 12. Will there continue to be a new patient and established patient designation?

The new E/M codes will have codes for both new and established patients and are defined as: (1) a new patient is one who has not received any professional services from the physician within the past three years; and (2) an established patient is one who has received professional services from the physician within the past three years.

*(continued on page 323)*

In CPT code 99202, these three key components must be present:

- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making.

Note that the type of history and examination required is different for EACH of these codes in this outpatient new patient category.

4. Next, determine the extent of **HISTORY** obtained. Look at the list of definitions. There are four types of history defined.

The type of history documented in the patient's record helps determine which level of E/M code will finally be selected. Note that the type of history varies in each of the codes in the new patient office and outpatient category, except for codes 99204 and 99205 which both require that a comprehensive history be taken and documented. (You will also note, however, that the type of medical decision making varies in these two codes. Medical decision making will be discussed separately.)

5. Determine the extent of **EXAMINATION** performed. Refer to the list of definitions. There are four types of examination defined.

In each of the codes we've discussed thus far, the type of examination performed has varied, depending on the code discussed.

The final component of these three key components, medical decision making, is discussed in number 6.

6. Determine the complexity of **MEDICAL DECISION MAKING**: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. Refer to your list of definitions.

To demonstrate how to determine the complexity of medical decision making, an example may be helpful. (Refer to the table under Medical Decision Making.)

If the number of diagnoses or management options is **LIMITED**, the amount and/or complexity data to be reviewed is **MODERATE**, and the risk of complications and/or morbidity or mortality is **MODERATE**, the decision making is of moderate complexity (i.e., two of the three elements in the table must be met or exceeded). To carry this example to the selection of a code: This moderate complexity of decision making, plus a comprehensive examination (as defined under point 5) and a comprehensive history (as defined under point 4) would qualify the physician to report 99204 (i.e., the

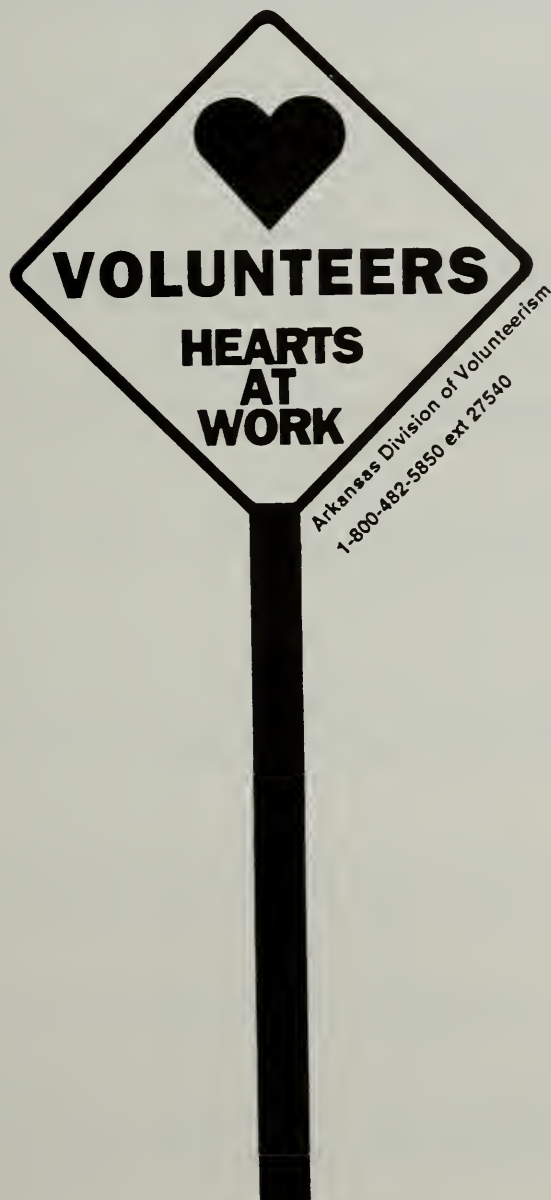


documentation in the patient's record would indicate that the three key components were performed).

Because counseling and/or coordination of care did not play a dominant role in the example just given, time is not considered a key or controlling factor in code selection. The content of the service is the basis for the selection of code 99204. Although the typical time is listed as 45 minutes, it is immaterial whether the physician completed these services in 5 minutes or 50 minutes.

**One additional note:**

The actual performance of diagnostic tests/studies for which specific CPT codes are available is **not** included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available should be reported separately, in addition to the appropriate visit code.



No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

**13. Can modifiers be used with the new codes?**

There are three modifiers that may be used with the new E/M codes.

**-21 Prolonged evaluation and management services:**

When the service(s) provided is prolonged or otherwise greater than that usually required for the highest level of E/M service within a given category, it may be identified by adding modifier '-21' to the E/M code number or by use of the separate five digit modifier code 09921. A report may also be appropriate.

**-32 Mandated Services:**

Services related to mandated consultation and/or related services (e.g., PRO, 3rd party payor) may be identified by adding the modifier '-32' to the basic procedure or the service may be reported by use of the five digit modifier 09932.

**-52 Reduced Services:**

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '-52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Modifier code 09952 may be used as an alternative to modifier '-52'.

You will note that modifier -21 is to be used only with the highest level of E/M service within a given category.

**14. If I perform an E/M service and a distinct, separately identifiable procedure (e.g., 11770 - Excision of pilonidal cyst or sinus; simple) at the same office visit, can I report both services?**

Procedures/diagnostic tests (for which specific CPT codes are available) performed by the physician in addition to E/M services must be documented in the medical record.



# Complete Listing of the New Evaluation & Management Codes

## OFFICE & OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the physician's office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital inpatient care (page 328) or comprehensive nursing facility assessments (page 337).

For services provided by physicians in the Emergency Department, see 99281-99285.

The codes for office and other outpatient services are also used to report the services provided by a physician to a patient in an observation area of a hospital.

### New Patient

**99201** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

#### Examples

*Internal Medicine:* Office visit with an out-of-town visitor who needs a prescription refilled because she forgot her hay fever medication.

*Oral and Maxillofacial Surgery:* Office visit to advise for or against the removal of wisdom teeth, 18-year-old male referred by an orthodontist.

**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

#### Examples

*Dermatology:* Initial office visit, 16-year-old male with severe cystic acne, new patient.

*Internal Medicine:* Initial evaluation and management of recurrent urinary infection in female.

*Orthopedics:* First visit for evaluation and counseling of 28-year-old male runner with knee and calf pain.

*Otolaryngology:* Initial office evaluation for gradual hearing loss, 58-year-old male, history and physical examination, with interpretation of complete audiogram, air bone, etc.

**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.



Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

#### Examples

**Internal Medicine:** Initial office evaluation for diagnosis and management of painless gross hematuria in new patient, without cystoscopy.

**Orthopedics/Physical Medicine:** Initial office visit for evaluation of 13-year-old female with progressive scoliosis.

**General Surgery:** Office visit for initial evaluation of a 48-year-old man with recurrent low back pain radiating to the leg.

**Urology:** Initial evaluation and management of recurrent renal calculi in 40-year-old male.

**Obstetrics/Gynecology:** Initial office evaluation of secondary amenorrhea, in 22-year-old new patient, pregnancy excluded.

- 99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- a comprehensive history;
  - a comprehensive examination; and
  - medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

#### Examples

**Thoracic Surgery:** Initial office evaluation of a 50-year-old male with an aortic aneurysm with respect to recommendation for surgery.

**Internal Medicine:** Initial office evaluation of a 70-year-old patient with recent onset of episodic confusion.

**Cardiology:** Office visit for initial evaluation of a 63-year-old male with chest pain on exertion.

**Urology:** Initial evaluation and management of unexplained renal failure in a 40-year-old female.

**Obstetrics/Gynecology:** Initial office visit for 34-year-old patient with primary infertility, including counseling.

**Rheumatology:** Initial office evaluation of 70-year-old female with polyarthralgia.

- 99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
- a comprehensive history;
  - a comprehensive examination; and
  - medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

#### Examples

**Hematology/Oncology:** Initial office visit for a 73-year-old male with an unexplained 20-pound weight loss.

**Infectious Disease:** Initial office visit for a 24-year-old homosexual male who has a fever, a cough, and shortness of breath.

**Rheumatology:** Initial office evaluation, patient with systemic lupus erythematosus, fever, seizures and profound thrombocytopenia.

**Rheumatology:** Initial office evaluation and management of patient with systemic vasculitis and compromised circulation to the limbs.

### **Established Patient**

The following codes are used to report the evaluation and management services provided to established patients who present for follow-up and/or periodic reevaluation of problems or for the evaluation and management of new problem(s) in established patients.

- 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal.

Typically, 5 minutes are spent performing or supervising these services.



### Example

*Internal Medicine:* Cursory check in your office for an established patient with hematoma one day after venipuncture.

- 99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a problem focused history
  - a problem focused examination;
  - straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

### Examples

*Pediatrics/Internal Medicine/Family Practice:* Office evaluation for possible purulent bacterial conjunctivitis with 1-2 day history of redness and discharge, 16-year-old female patient.

*Internal Medicine:* Office visit with a 65-year-old established patient with eruption on both arms from poison oak exposure.

*Family Practice/Pediatrics:* Office visit, established patient, 6-year-old child with sore throat and headache.

- 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- an expanded problem focused history;
  - an expanded problem focused examination; and
  - medical decision making of low complexity.

Counseling and coordination of care are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

### Examples

*Family Practice/Internal Medicine:* Follow-up visit with 55-year-old male for management of

hypertension, mild fatigue, on beta blocker/thiazide regimen.

*Gastroenterology:* Follow-up office visit for an established patient with stable cirrhosis of the liver.

*Pulmonary Medicine:* Quarterly follow-up office visit for a 45-year-old male, with stable chronic asthma, on steroid and bronchodilator therapy.

*Rheumatology/Orthopedics:* Office visit, established patient with known osteoarthritis and painful swollen knees.

*Hematology/Oncology:* Routine, follow-up office evaluation at a three-month interval for a 77-year-old female with nodular small cleaved-cell lymphoma.

*Internal Medicine:* Follow-up visit for a 70-year-old diabetic hypertensive patient with recent change in insulin requirement.

- 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a detailed history;
  - a detailed examination;
  - medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

### Examples

*Family Practice/Internal Medicine:* Office evaluation of 28-year-old patient with regional enteritis, diarrhea and low grade fever, established patient.

*Urology/General Surgery/Internal Medicine/Family Practice:* Office evaluation of new onset RLQ pain in a 32-year-old woman, established patient.

*Cardiology:* Office visit for a 68-year-old male with simple angina, two months post myocar-



dial infarction, who is not tolerating one of his medications.

**Hematology/Oncology:** Weekly office visit for 5FU therapy for an ambulatory established patient with metastatic colon cancer and increasing shortness of breath.

**Neurology:** Follow-up office visit for a 60-year-old male whose post-traumatic seizures have disappeared on medication, and who now raises the question of stopping the medication.

**Rheumatology:** Follow-up office visit for a 45-year-old patient with rheumatoid arthritis on gold, methotrexate, or immunosuppressive therapy.

- 99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a comprehensive history;
  - a comprehensive examination;
  - medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

#### Examples

**Neurology:** Follow-up office visit for a 75-year-old patient with ALS (amyotrophic lateral sclerosis), who is no longer able to swallow.

**Rheumatology:** Follow-up visit, 40-year-old mother of 3, with acute rheumatoid arthritis, anatomical Stage 3, ARA function Class 3 rheumatoid arthritis, and deteriorating function.

**Internal Medicine:** Office visit for evaluation of recent onset syncopal attacks in a 70-year-old woman, established patient.

**General Surgery:** Office evaluation and discussion of treatment options for a 68-year-old male with a biopsy-proven rectal carcinoma.

**Infectious Disease:** Follow-up office visit for a 65-year-old male with a fever of recent onset while on outpatient antibiotic therapy for endocarditis.

### Category/Subcategory of E/M Codes\*

These are the categories and subcategories of E/M codes that will be found in CPT 1992 in the new Evaluation and Management Section. The sequence of these codes is as listed below:

<u>Category/Subcategory</u>	<u>Code Numbers</u>
Office or other outpatient services	
New patient	99201-99205
Established patient	99211-99215
Hospital Inpatient Services	
Initial hospital care	99221-99223
Subsequent hospital care	99231-99233
Hospital discharge services	99238
Consultations	
Office consultations	99241-99245
Initial inpatient consultations	99251-99255
Follow-up inpatient consultations	99261-99263
Confirmatory consultations	99271-99275
Emergency department services	99281-99288
Critical care services	99291-99292
Nursing facility (n.f.) services	
Comprehensive n.f. assessments	99301-99303
Subsequent n.f. care	99311-99313
Domiciliary, rest home, or custodial services	
New patient	99321-99323
Established patient	99331-99333
Home services	
New patient	99341-99343
Established patient	99351-99353
Case management services	
Team conferences	99361-99363
Telephone calls	99371-99373
Preventive medicine services	
New patient	99381-99387
Established patient	99391-99397
Individual counseling	99401-99404
Group counseling	99411-99412
Other	99420-99429
Newborn care	99431-99440
Other E/M services	99499

\* This information is presented as a teaching tool. The user, when actually reporting the new codes, must refer to the complete set of guidelines which precede all of the new evaluation and management codes in CPT 1992 and the specific instructions in each category or subcategory.



*Hematology/Oncology:* Office visit for restaging of an established patient with new lymphadenopathy one year post therapy for lymphoma.

## HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a 'partial hospital' setting. See also psychiatry notes on page \_\_\_\_.

### Initial Hospital Care

These codes are to be used to report partial hospitalization services. (See also psychiatry notes, page \_\_\_\_.)

#### New or Established Patient

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.

When the patient is admitted to the hospital in the course of an encounter in another site of service (eg, hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting. Evaluation and management services on the same date provided in sites other than the hospital that are related to the admission should NOT be reported separately.

**99221** Initial hospital care, per day, for the evaluation and management of a which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of

low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

*Pediatrics:* Hospital admission for an 18-month-old child with 10 percent dehydration.

*Internal Medicine:* Hospital admission, examination, and initiation of treatment program for a 67-year-old male with an uncomplicated pneumonia who requires IV antibiotic therapy.

**99222** Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

*Family Practice/Allergy Immunology:* Direct hospital admission, young adult patient, failed previous therapy and now presents in acute asthmatic attack.

*Internal Medicine/Pulmonary Medicine:* Direct hospital admission of a 62-year-old smoker, established patient, with bronchitis in acute respiratory distress.

*Physical Medicine:* Hospital admission, examination, and initiation of a treatment program for a chronic paraplegic, established patient, with a recent third degree burn of the ankle.

*Nephrology:* Hospital admission, examination, and initiation of treatment program for a 66-year-old chronic hemodialysis patient with fever and a new pulmonary infiltrate.

*Neurology:* Hospital admission, examination, and initiation of a treatment program for a 65-year-old female with new onset of right-sided paralysis and aphasia.



**99223** Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

*Cardiology:* Hospital admission, examination, and initiation of treatment program for a previously unknown 58-year-old male who presents with acute chest pain.

*Hematology/Oncology:* Hospital admission, examination, and initiation of induction chemotherapy for a 42-year-old patient with newly diagnosed acute myelogenous leukemia.

*Infectious Disease:* Hospital admission, examination, and initiation of treatment program for a 65-year-old immunosuppressed male with confusion, a fever, and a headache.

### **Subsequent Hospital Care**

All levels of service include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (i.e., changes in history, physical condition and response to management) since the last assessment by the physician.

**99231** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

*Gastroenterology:* Follow-up hospital visit for a 67-year-old male admitted three days ago for a bleeding gastric ulcer, who is now stable.

*Neurology:* Follow-up hospital visit, two days post admission for a 65-year-old male with a CVA (cerebral vascular accident) and left hemiparesis, who is clinically stable.

*Hematology/Oncology:* Follow-up hospital visit for a stable 72-year-old lung cancer patient undergoing a five day course of infusion chemotherapy.

*Internal Medicine:* Hospital visit, day three post admission, 65-year-old male with an uncomplicated MI (myocardial infarction), established patient.

*Infectious Disease/Internal Medicine/Pulmonary Medicine:* Follow-up visit on third day of hospitalization for a 60-year old female recovering from an uncomplicated pneumonia.

*Cardiology:* Follow-up hospital visit for a 67-year-old patient, post uncomplicated MI (myocardial infarction), who is now in a regular room.

**99232** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and/or on the patient's hospital floor or unit.

#### Examples

*Cardiology/Internal Medicine:* Follow-up hospital visit for a 54-year-old patient, post MI (myocardial infarction), who is out of the CCU



(coronary care unit) but is now having frequent premature ventricular contractions on telemetry.

**Pulmonary Medicine:** Follow-up hospital visit for a 73-year-old female with recently diagnosed lung cancer, who complains of unsteady gait.

**Hematology:** Follow-up hospital visit for a patient with neutropenia, a fever responding to antibiotics, and continued slow gastrointestinal bleeding on platelet support.

**Nephrology:** Follow-up hospital visit for a 50-year-old male admitted two days ago for subacute renal allograft rejection.

**Oncology:** Follow-up visit for a stable but nauseated patient with AML (acute myelogenous leukemia), in remission, hospitalized for administration of consolidation chemotherapy.

**99233** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination;
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

**Infectious Disease:** Follow-up hospital visit for a 60-year-old female with persistent leukocytosis and a fever seven days after a sigmoid colon resection for carcinoma.

**Hematology/Oncology:** Follow-up hospital visit for a patient with AML (acute myelogenous leukemia), fever, elevated white count and uric acid, undergoing induction chemotherapy.

**Physical Medicine:** Follow-up hospital visit for a 38-year-old quadriplegic male with acute autonomic hyperreflexia, who is not responsive to initial care.

## Hospital Discharge Services

(Final day of a multiple day stay.)

(To report services to a patient who is admitted as an inpatient and discharged on the same day, use only the appropriate code for Initial Hospital Inpatient Services, 99221-99223.)

Final Hospital care for discharge of a patient includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

**99238** Hospital discharge day management.

## CONSULTATIONS

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. A consultant may initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source and the need for consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated to the requesting physician or other appropriate source.

A "consultation" initiated by a patient and/or family, and not requested by another physician, is not reported using the initial consultation codes but may be reported using the codes for confirmatory consultation or office visits, as appropriate. If a confirmatory consultation is required, e.g., by a third party payor, the modifier -32, mandated services, should also be reported.

Any specifically identifiable procedure performed on or subsequent to the date of the initial consultation should be reported separately.

A consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used. In the hospital setting, the physician receiving the patient for partial or complete transfer of care should use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient code should be used.

There are four sub-categories of consultations: office, initial inpatient, follow-up inpatient, and confirmatory. See notes for each sub-category for specific reporting instructions.



## Office and Other Outpatient Consultations

### New or Established Patient

The following codes are used to report consultations provided in the physician's office or in an outpatient or other ambulatory facility, including an emergency department. (See consultation definition, page 330.) Follow-up visits in the consultant's office that are initiated by the consultant are reported using office visit codes for established patients (see 99211-99215). If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used again.

- 99241** Office consultation for a new or established patient, which requires these three key elements:
- a problem focused history;
  - a problem focused examination; and
  - straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

**NOTE:** There are no examples yet available.

- 99242** Office consultation for a new or established patient, which requires these three key elements:
- an expanded problem focused history;
  - an expanded problem focused examination; and
  - straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

#### Example

**General Surgery:** Initial office consultation for evaluation of a 45-year-old female referred for recurrent symptomatic cholelithiasis.

- 99243** Office consultation for a new or established patient, which requires at least two of these

three key elements:

- a detailed history;
- a detailed examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

#### Examples

**Infectious Disease:** Initial office consultation for a 65-year-old female with persistent bronchitis.

**Neurology:** Initial office consultation for a 65-year-old man with chronic low-back pain radiating to the leg.

- 99244** Office consultation for a new or established patient, which requires these three key elements:
- a comprehensive history;
  - a comprehensive examination; and
  - medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

#### Example

**Radiation Oncology:** Initial office consultation for discussion of treatment options for a 40-year-old female with a two-centimeter adenocarcinoma of the breast.

- 99245** Office consultation for a new or established patient, which requires these three key elements:
- a comprehensive history;
  - a comprehensive examination; and
  - medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate



to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

**NOTE:** There are no examples yet available.

## Initial Inpatient Consultations

### New or Established Patient

The following codes are used to report consultations provided to hospital inpatients or residents of nursing facilities only. Only one initial consultation should be reported by a consultant per admission.

**99251** Initial inpatient consultation for a new or established patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

**NOTE:** There are no examples yet available.

**99252** Initial inpatient consultation for a new or established patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

*Dermatology:* Hospital consultation for possible drug eruption in 50-year-old male.

*Internal Medicine:* Preoperative hospital consultation for evaluation of hypertension in a 60-year-old male who will undergo a cholecystec-

tomy. Patient had a normal annual check-up in your office four months ago.

**99253** Initial inpatient consultation for a new or established patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

*Physical Medicine:* Initial hospital consultation for rehabilitation of a 73-year-old female one week after surgical management of a hip fracture.

*Internal Medicine:* Hospital consultation for diagnosis/management of fever following abdominal surgery.

*Pulmonary Medicine:* Initial hospital consultation for a 35-year-old female with a fever and pulmonary infiltrate following caesarean section.

**99254** Initial inpatient consultation for a new or established patient, which requires three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

### Examples

*Nephrology:* Initial hospital consultation for evaluation of a 71-year-old male with hyponatremia (serum sodium 114) who was admitted to the hospital with pneumonia.



**Anesthesiology:** Evaluation of 63-year-old in the ICU with diabetes and chronic renal failure who develops acute respiratory distress syndrome 36 hours after a mitral valve replacement.

**Pulmonary Medicine:** Initial hospital consultation with extended review of records for a 63-year-old smoker who collapsed while walking up an incline. Chest x-ray reveals cardiomegaly and pulmonary opacities.

**Hematology/Oncology:** Initial hospital consultation for a 66-year-old female with enlarged supraclavicular lymph nodes, found on biopsy to be malignant.

**Rheumatology:** Consultation in hospital for 35-year-old female with fever, swollen joints, and rash of one week duration.

**General Surgery:** Emergency hospital consultation for possible bowel obstruction in a 72-year-old patient.

99255 Initial inpatient consultation for a new or established patient, which requires these three key component:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

#### **Examples**

**Cardiology:** Initial consultation in the ICU for a 70-year-old male who experienced a cardiac arrest during surgery and was resuscitated.

**Gastroenterology:** Initial hospital consultation for a 70-year-old cirrhotic male admitted with ascites, jaundice, encephalopathy, and massive hematemesis.

**General Surgery/Orthopedics:**

Initial evaluation and formulation of plan for management of multiple trauma patient with complex pelvic fracture, 35-year-old male.

**Infectious Disease:** Initial consultation in the ICU for a 51-year-old patient who is on a ventilator and has a fever two weeks after a renal transplantation.

**Neurosurgery:** Initial consultation in the emergency room for a 25-year-old male with severe, acute, closed head injury.

**Nephrology:** Initial hospital consultation for a 66-year-old female two days post abdominal aneurysm repair, with oliguria and hypotension of one-day duration.

## **Follow-up Inpatient Consultations**

### **Established Patient**

Follow-up consultations are visits to complete the initial consultation OR subsequent consultative visits requested by the attending physician. A follow-up consultation includes monitoring progress, recommending management modifications or advising on a new plan of care in response to changes in the patient's status.

If the consultant has initiated treatment at the initial consultation, and participates thereafter in the patient's management, the codes for subsequent hospital care should be used (see 99231-99233).

The following codes are used to report follow-up consultations provided to hospital inpatients or nursing facility residents only. For consultative services provided in other settings, the codes for office consultations should be used (see 99241-99245).

99261 Follow-up inpatient consultation for an established patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's hospital floor or unit.

#### **Example**

**Neurology:** Follow-up consultation for a 74-year-old male whose postoperative facial paralysis after a cholecystectomy is now resolving.



99262 Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

*Infectious Disease:* Follow-up hospital consultation for a 71-year old male who has developed a maculopapular skin rash while on antibiotics that you recommended for an uncomplicated pneumonia.

*Neurology:* Follow-up hospital consultation for reevaluation of a stroke patient, and development of plan for initial rehabilitation services.

99263 Follow-up inpatient consultation for an established patient which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.

#### Examples

*Infectious disease:* Follow-up hospital consultation for an HIV-positive patient with an increasing fever following ten days of antibiotic therapy for pneumocystis carinii pneumonia.

## Confirmatory Consultations

### New or Established Patient

These following codes are used to report the evaluation and management services provided to patients when the consulting physician is aware of the confirmatory nature of the opinion sought (eg, when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure). Confirmatory consultations may be provided in any setting.

Consultant providing a confirmatory consultation is expected to provide an opinion and/or advice only. Any services subsequent to the opinion are coded at the appropriate level of office visit, established patient, or subsequent hospital care.

Typical times have not been established for this sub-category of services.

99271 Confirmatory consultation for a new or established patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

**NOTE: There are no examples yet available.**

99272 Confirmatory consultation for a new or established patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

**NOTE: There are no examples yet available.**

99273 Confirmatory consultation for a new or established patient, which requires these three key



components:

- a detailed history;
- a detailed examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**NOTE: There are no examples yet available.**

**99274** Confirmatory consultation for a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity.

**NOTE: There are no examples yet available.**

**99275** Confirmatory consultation for a patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity.

**NOTE: There are no examples yet available.**

## EMERGENCY DEPARTMENT SERVICES

### New or Established Patient

The following codes are used to report evaluation and management services provided in the emergency

department. No distinction is made between new and established patients in the emergency department. An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day. For critical care services provided in the Emergency Department, see critical care notes and 99290-99292.

For evaluation and management services provided to a patient in observation area of a hospital see 99201-99215.

**99281** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor.

**NOTE: There are no examples yet available.**

**99282** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity.

**NOTE: There are no examples yet available.**

**99283** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of low complexity.



Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**NOTE: There are no examples yet available.**

**99284** Emergency department visit for the evaluation and management of a patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

**NOTE: There are no examples yet available.**

**99285** Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

**NOTE: There are no examples yet available.**

#### Miscellaneous

In physician directed emergency care, advanced life support, the physician is located in a hospital emergency or critical care department, and is in two-way voice communication with ambulance or rescue personnel outside the hospital. The physician directs the performance of necessary medical procedures, includ-

ing but not limited to: telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous fluids and/or administration of intramuscular, intratracheal or subcutaneous drugs; and/or electrical conversion of arrhythmia.

**99288** Physician direction of emergency medical systems (EMS) emergency care, advanced life support.

## CRITICAL CARE

Critical care includes the care of critically ill patients in a variety of medical emergencies that requires the constant attention of the physician (eg, cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility.

The descriptors for critical care are intended to include cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Services for a patient who is not critically ill but happens to be in a critical care unit are reported using subsequent hospital care codes (see 99231-99233).

Services performed during the critical period (eg, placement of catheters, cardiac output measurement, tube thoracostomy, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, endotracheal intubation, management of mechanical ventilation, blood gas monitoring) are included.

The codes are used to report the total duration of time spent by a physician providing constant attention to a critically ill patient. Code 99290 is used to report the first hour of critical care on a given day. It should be used only once per day even if the time spent by the physician is not continuous on a that day. Code 99292 is used to report each additional 30 minutes beyond the first hour. For example, if 1 hour of critical care is provided at 10AM and 2 hours provided from 3PM to 5PM, then report code 99290 once and 99292 four times to report the total of three hours on a single day.

Other procedures which are not directly attendant to critical care management (eg, the suturing of lacerations, setting of fractures, reduction of joint dislocations, lumbar puncture, peritoneal lavage, bladder tap) are not included in critical care and should be reported separately.

**99290** Critical care, including the diagnostic and therapeutic services and direction of care of the



critically ill or multiply injured or comatose patient, requiring the prolonged presence of the physician; first hour.

99292 Each additional 30 minutes.

## NURSING FACILITY

The following codes are used to report evaluation and management services to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs).

These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center (a facility or a distinct part of a facility for psychiatric care, which provides a 24 hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be listed separately.

Nursing facilities that provide convalescent, rehabilitative, or long term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs specify triggers that identify potential problems and provide guidelines for follow-up assessments. Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning. Two sub-categories of nursing facility services are recognized: Comprehensive Nursing Facility Assessments and Subsequent Nursing Facility Care. Both sub-categories apply to new or established patients. Comprehensive Assessments may be performed at one or more sites in the assessment process: the hospital, office, nursing facility, domiciliary/non-nursing facility or patient's home. Typical times have not been established for this category of services.

### Comprehensive Nursing Facility Assessments

#### New or Established Patient

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency room, physician's office), all evaluation and management services provided by that physician in conjunction with that admission are con-

sidered part of the initial nursing facility care when performed on the same date as the admission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well in the nursing facility setting. With the exception of hospital discharge services, evaluation and management services on the same date provided in sites other than the nursing facility that are related to the admission should NOT be reported separately. Hospital discharge services may be reported separately.

More than one comprehensive assessment may be necessary during an admission.

**99301** Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components:

- a detailed interval history;
- a comprehensive examination; and
- straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required.

**NOTE:** There are no examples yet available.

**99302** Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components:

- a detailed internal history;
- a comprehensive examination; and
- medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status. The creation of a new medical plan of care is required.

**NOTE:** There are no examples yet available.

**99303** Evaluation and management of a new or established patient involving a nursing facility as-



assessment at the time of initial admission to the facility, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

The creation of a medical plan of care is required.

**NOTE: There are no examples yet available.**

## Subsequent Nursing Facility Care

### New or Established Patients

All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

Typical times have not been established for this category of services.

- 99311 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:
- a problem focused interval history;
  - a problem focused examination; and
  - straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. A revision of the medical plan of care is not required.

**NOTE: There are no examples yet available.**

- 99312 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:
- a problem focused interval history;
  - a problem focused examination; and
  - medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the

nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. A revision of the medical plan of care or a written justification for continuation of treatment is required.

**NOTE: There are no examples yet available.**

- 99313 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient which requires at least two of these three key components:
- an expanded problem focused interval history;
  - an expanded problem focused examination; and
  - medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to treatment or has developed a minor problem. A revision of the medical plan of care is not required.

**NOTE: There are no examples yet available.**

- 99314 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:
- an expanded problem focused interval history;
  - an expanded problem focused examination; and
  - medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to treatment or has developed a minor. A revision of the medical plan of care is required.

**NOTE: There are no examples yet available.**

- 99315 Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components:



- a detailed interval history;
- a detailed examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem, but has not had a major permanent change in status. A revision of the medical plan of care is not required.

**NOTE:** There are no examples yet available.

## DOMICILIARY, REST HOME (EG, BOARDING HOME), OR CUSTODIAL CARE SERVICES

The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The facility's services do not include a medical component.

Typical times have not been established for this category of services.

### New Patient

- 99321** Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components:
- a problem focused history;
  - a problem focused examination; and
  - medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

**NOTE:** There are no examples yet available.

- 99322** Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:
- an expanded problem focused history;
  - an expanded problem focused examination; and
  - medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**NOTE:** There are no examples yet available.

- 99323** Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high complexity.

**NOTE:** There are no examples yet available.

### Established Patient

- 99331** Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- a problem focused interval history;
  - a problem focused examination; and
  - medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

**NOTE:** There are no examples yet available.

- 99332** Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- an expanded problem focused interval history;
  - an expanded problem focused examination; and
  - medical decision making of moderate complexity.



Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication.

**NOTE: There are no examples yet available.**

**99333** Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

**NOTE: There are no examples yet available.**

## HOME SERVICES

The following codes are used to report evaluation and management services provided in a private residence.

Typical times have not been established for this category of services.

### New Patient

**99341** Home visit for the evaluation and management of a new patient, which requires these three key components:

- a problem focused history;
- a problem focused examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low severity.

**NOTE: There are no examples yet available.**

**99342** Home visit for the evaluation and management of a new patient, which requires these three key

components:

- an expanded problem focused history;
- an expanded problem focused examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity.

**NOTE: There are no examples yet available.**

**99343** Home visit for the evaluation and management of a new patient, which requires these three key components:

- a detailed history;
- a detailed examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of high severity.

**NOTES: There are no examples yet available.**

### Established Patients

**99351** Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a problem focused interval history;
- a problem focused examination; and
- medical decision making that is straightforward or of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving.

**NOTE: There are no examples yet available.**

**99352** Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- an expanded problem focused interval



history;

- an expanded problem focused examination; and
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or who has developed a minor complication.

**NOTE:** There are no examples yet available.

**99353** Home visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed interval history;
- a detailed examination; and
- medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is unstable or has developed a significant complication or a significant new problem.

**NOTE:** There are no examples yet available.

## CASE MANAGEMENT SERVICES

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services, needed by the patient.

### Team Conferences

**99361** Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient (patient not present); approximately 30 minutes.

**99362** Approximately 60 minutes.

### Telephone Calls

**99371** Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other

health care professionals (eg, nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (eg, to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy).

**99372** Intermediate (eg, to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care).

**99373** Complex or lengthy (eg, lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan).

## PREVENTIVE MEDICINE SERVICES

The following codes are used to report the routine evaluation and management of adults and children when these services are performed in the absence of patient complaints. The extent and focus of the services will largely depend on the age of the patient, the circumstances of the examination, and the abnormalities are encountered.

Codes 99371-99387 do not include counseling, risk factor reduction interventions or immunizations. For counseling and/or risk factor reduction interventions, see 99391-99396. For immunizations, see 90741-90749. Ancillary studies involving laboratory, radiology, or other procedures are reported separately.

### New Patient

**99381** Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures, new patient; infant (age under 1 year).

**99382** Early childhood (age 1 through 4 years)

**99383** Late childhood (age 5 through 11 years)

**99384** Adolescent (age 12 through 17 years)



- 99385 18-39 years
- 99386 40-64 years
- 99387 65 years and over

### Established Patient

- 99391 Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)
- 99392 Early childhood (age 1 through 4 years)
- 99393 Late childhood (age 5 through 11 years)
- 99394 Adolescent (age 12 through 17 years)
- 99395 18-39 years
- 99396 40-64 years
- 99397 65 years and over

### Counseling and/or Risk Factor Reduction Intervention

#### New or Established Patient

These codes are used to report services provided to healthy individuals for the purpose of promoting health and preventing illness or injury. Counseling and risk factor reduction interventions provided in conjunction with an initial or periodic preventive medicine visit will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention and dental health.

These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illnesses, use the appropriate office, hospital or consultation or other evaluation and management codes. For counseling groups of patients with symptoms or established illnesses, use 99078.

### Preventive Medicine, Individual Counseling

- 99401 Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes.
- 99402 Approximately 30 minutes
- 99403 Approximately 45 minutes
- 99404 Approximately 60 minutes

### Preventive Medicine, Group Counseling

- 99411 Counseling and/or risk factor reduction intervention(s) provided to healthy individuals

- in a group setting; approximately 30 minutes.
- 99412 Approximately 60 minutes.

### Other Preventive Medicine Services

- 99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal).
- 99429 Unlisted preventive medicine service.

## NEWBORN CARE

The following codes are used to report the services provided to normal or high risk newborns in several different settings. For hospital discharge services, use 99238.

- 99431 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)
- 99432 Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conference(s) with parent(s).
- 99433 Subsequent hospital care, for the evaluation and management of a normal newborn, per day.
- 99438 Infant care to one year of age, with a maximum of 12 office visits during regular office hours, including tuberculin skin testing and administration of DTP and oral polio vaccine.
- 99440 Newborn resuscitation: care of the high risk newborn at delivery, including, for example, inhalation therapy, aspiration, administration of medication for initial stabilization.

## OTHER EVALUATION AND MANAGEMENT SERVICES

- 99499 Unlisted evaluation and management service.





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# New Members

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## **CRAIGHEAD/POINSETT COUNTY**

**Crit, Reon C.**, Child & Adult Psychiatry, Jonesboro. Born, March 20, 1957, Fort Smith. Medical education, UAMS, 1985. Internship/residency, Martin Luther King/Drew/Augustus R. Hawkins, Los Angeles, CA, 1988. Board eligible. Practice experience, 1 year.

## **CROSS COUNTY**

**Roberson, Charles D.**, General Surgery, Wynne. Born, August 29, 1936, White's Creek, TN. Medical education, University of Tennessee, Memphis, 1962. Internship/residency, St. Joseph Mercy Hospital, Ann Arbor, MI, 1967. Practice experience, 23 years.

## **JEFFERSON COUNTY**

**Atiq, Omar T.**, Oncology/Hematology, Pine Bluff. Born, October 6, 1960, Peshawar, Pakistan. Medical education, Khyber Medical College, University of Peshawar, Pakistan, 1983. Internship/residency, Edward Hines Jr. VA Hospital/Foster G. McGaw Hospital, Loyola, 1988. Board certified.

## **PHILLIPS COUNTY**

**Tukivakala, Prabhakara R.**, Internal Medicine, Helena. Born, September 28, 1947, Tirupati, India. Medical education, Guntur Medical College, India, 1970. Residency, St. Agnes Hospital, Baltimore, MD, 1982. Board eligible. Practice experience, 9 years.

## **POPE COUNTY**

**Murphy, David S.**, Ophthalmology, Russellville. Born, October 25, 1959, Staten Island, NY. Medical education, University of Texas Health Science Center, San Antonio, 1986. Internship, UAMS, 1988. Residency, New York Medical College, 1991. Board eligible.

## **PULASKI COUNTY**

**Davis, Carole L.**, Physical Medicine & Rehabilitation, Sherwood. Born, July 26, 1949, Pawnee City, NE. Medical school, Hadassah Medical School, Jerusalem, Israel, 1982; College of Osteopathic Medicine, Des Moines, Iowa, 1987. Internship/residency, Loyola University, Chicago, IL; Hines VA Hospital, Hines, IL; Marianjoy Rehabilitation Center, Wheaton, IL, 1991. Board eligible.

**Knott, Patricia A.**, Physical Medicine & Rehabilitation, Sherwood. Born, March 31, 1958, Hollandale,

MS. Medical education, Louisiana State University, New Orleans, 1987. Internship/internship, Charity Hospital, LSU Medical Center, 1991. Board eligible.

**Miers, Jane F.**, Pediatrics, Sherwood. Born, November 3, 1960, Great Bend, KS. Medical education, Southwestern Medical School, Dallas, TX, 1987. Internship, UAMS, 1988. Residency, Arkansas Childrens Hospital, Little Rock, 1990. Practice experience, 1 year. Board certified.

## **UNION COUNTY**

**Ulmer, Minna P.**, Anesthesiology, El Dorado. Born September 12, 1950, Greenwood, MS. Medical education, University of Mississippi Medical Center, Jackson, 1982. Internship/residency, University of Mississippi Medical Center, Jackson, 1985. Practice experience, 6 years. Board certified.

## **MEMBERS-AT-LARGE**

### *Bentonville*

**McKenzie, James M.**, Orthopedic Surgery. Born, November 11, 1959, Little Rock. Medical education, UAMS, 1986. Internship/residency, UAMS, 1991.

### *Camden*

**Nayles, Lee C.**, Family Practice. Born, February 11, 1943, Camden. Medical education, UAMS, 1981. Internship, Henry Ford Hospital, 1982. Residency, Medical University of South Carolina. Practice experience, 7 years.

### *Conway*

**Dobbs, John C.**, Family Practice. Born, October 3, 1946. Medical education, UAMS, 1972. Internship, St. Vincent Infirmary Medical Center, Little Rock, 1973. Board certified. Practice experience, 18 years.

### *Fort Smith*

**Builtman, Cynthia M.**, Anesthesiology. Born, January 18, 1958, Joliet, IL. Medical education, UAMS, 1984. Internship/residency, University Hospital, Little Rock, 1987. Board certified. Practice experience, 4 years.

**Holland, Jerry M.**, Psychiatry. Born, July 9, 1958, Fairfield, CA. Medical education, University of California, Irvine, 1986. Internship, St. Mary's Hospital & Medical Center, San Francisco, CA, 1987. Residency, University of California, Sacramento, 1990. Board eligible. Practice experience, 1 year.



### *Jonesboro*

**Cohen, Jeffrey O.**, Pulmonary Medicine. Born, January 6, 1959, Memphis, TN. Medical education, UAMS, 1985. Internship/residency, University of Michigan Hospital, 1988. Board certified. Practice experience, 1 year.

**Wood, Mark C.**, Internal Medicine. Born, July 12, 1960, Jonesboro. Medical education, UAMS, 1988. Internship/residency, UAMS, 1991. Pending certification.

### *Little Rock*

**Boop, Frederick A.**, Neurosurgery. Born, March 28, 1956, Memphis, TN. Medical education, UAMS, 1983. Internship/residency, University of Texas Health Science Center, San Antonio, 1989. Board eligible. Practice experience, 1 year.

**Bourne, David E.**, Family Practice. Born, August 27, 1954, Little Rock. Medical education, UAMS, 1983. Residency, UAMS, 1986. Board certified. Practice experience, 8 years.

**Eudy, Sidney F.**, Pathology. Born, July 20, 1948, Stehenville, TX. Medical education, UAMS, 1986. Residency, UAMS, 1991.

**SanPedro, Gerry S.**, Internal Medicine/Pulmonary & Critical Care Medicine. Born, November 13, 1959, Manila, Philippines. Medical education, UAMS, 1984. Internship/residency, UAMS, 1987. Practice experience, 1 year.

### *North Little Rock*

**Snyder, Victor F.**, Family Practice. Born, September 27, 1947, Oregon. Medical education, University of Oregon Health Science Center, Portland, 1979. Internship/residency, UAMS, 1982. Board certified. Practice experience, 9 years.

### *Paris*

**Alexander, Eugene H.**, Family Practice. Born, June 13, 1955, Baton Rouge, LA. Medical education, University of Health Sciences, Kansas City, MO, 1984. Internship/residency, Naval Hospital, Pensacola, FL, 1988. Board certified. Practice experience, 4 years.

### *Pine Bluff*

**Subramanyam, Nanjunda S.**, Family Practice. Born, July 16, 1951, Mysore, India. Medical education, Mahadeuappa Rampure Medical College, Gulbarga, India, 1975. Residency, 1991. Board certified.

### *Prairie Grove*

**Manning, Robert D.**, General Practice. Born, October 5, 1925, Ingersoll, Ontario, Canada. Medical education, Faculty Medicine, University of West Ontario, Canada, 1951. Internship, Victoria Hospital,

London, Ontario, Canada, 1952. Practice experience, 39 years.

### *Springdale*

**Floyd, Dennis N.**, Anesthesiology. Born, January 1, 1953, East St. Louis, IL. Medical education, UAMS, 1987. Internship/residency, UAMS, 1991.

## RESIDENTS

**Heiss, Nancy M.**, Family Practice, Fayetteville. Born, January 17, 1961, Wichita, KS. Medical education, UAMS, 1990. Internship, AHEC-NW, Fayetteville.

**Ohlhausen, Ward W.**, OB/GYN, Little Rock. Born, June 20, 1960, Kansas City, MO. Medical education, University of Missouri, Columbia, 1988. Internship/residency, UAMS.

**Ramsey, David B.**, Neurosurgery, Little Rock. Born March 31, 1962, Louisiana. Medical education, Texas Tech Health Sciences Center, Lubbock, TX, 1988. Internship/residency, UAMS.

## MEDICAL STUDENTS

Germer, Richard A.

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# AMS Newsmakers

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**Dr. Robert Benafield**, of Little Rock, has been named medical director of the health benefits management division at Arkansas Blue Cross & Blue Shield in Little Rock. Dr. Benafield has been with BC/BS for 18 years.

**Dr. Tim Boehm**, a Little Rock endocrinologist, has been named a lipid specialist after completing the lipid management training course at Washington University in St. Louis, MO, sponsored by the American Heart Association.

**Dr. John A. Gillean**, an internist from Texarkana, has been elected to the board of directors of St. Michael Hospital in Texarkana.

**Dr. William Golden**, director of the department of general internal medicine at the University of Arkansas for Medical Sciences in Little Rock, has been appointed to a two-year term on the liaison committee of medical education.

**Dr. A. Meryl Grasse**, a family physician from Calico Rock, has been named winner of the 1991 Distinguished Service Award presented by the Arkansas Hospital Association during its 61st annual meeting.

The AHA's Distinguished Service Award is presented each year to an individual who, while not an AHA member, has promoted a cause of the healthcare industry, thereby becoming entitled to special recognition.

**Dr. John M. Hodges**, an otolaryngologist-head and neck surgeon from Memphis/West Memphis, is one of 31 otolaryngologist-head and neck surgeons nationwide to receive the prestigious Honor Award. The award was presented at the opening ceremony of the 95th annual meeting of the American Academy of Otolaryngology-Head and Neck Surgery.

**Dr. Andrew Jansen III**, a family physician from Pocahontas, has been named a Fellow of the American Academy of Family Physicians (AAFP).

**Dr. Andrew Kumpuris**, a Little Rock cardiologist, has been named to the board of directors of Worthen National Bank of Arkansas. Dr. Kumpuris is medical director of coronary care and cardiac step-down unit at St. Vincent Infirmary Medical Center.

A science scholarship fund has been established at the Augusta High School in honor of **Dr. Frank C. Maguire Jr.** in appreciation for the decades of service he has given to the people of Augusta, Woodruff County and surrounding areas.

**Dr. Ladd J. Scriber**, a Jonesboro urologist, has been elected president of the Arkansas Urologic Society at the organization's last meeting in Hot Springs. Dr. Scriber has served as the secretary-treasurer for the past eight years.

**Dr. William White**, of Little Rock, has been named medical director of regular business for Arkansas Blue Cross & Blue Shield and USABLE Corp. in Little Rock. Dr. White is also clinical assistant professor of medicine at the University of Arkansas for Medical Sciences.

## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of September and October:

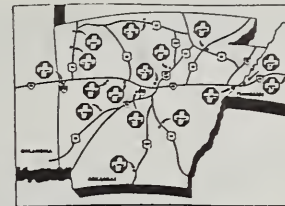
Michael Barnett	Heber Springs
William H. Benton	Little Rock
Lloyd G. Bess	Batesville
Doyne Dodd	Little Rock
W. Ray Jouett	Little Rock
Michael T. King	Little Rock
Paul C. Kramm	Sherwood
Charles A. Ledbetter	Harrison
Henry A. Lile	Little Rock
W. Brad Pierce	Little Rock
Narayanswami Rangaswami	Helena
William A. Runyan	Little Rock
E. Mitchell Singleton	Fayetteville
Steven K. Teplick	Little Rock





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F.R. Shrader, M.D.

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# In Memoriam

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## **L. Gordon Holt, M.D.**

Dr. L. Gordon Holt, former Pulaski County coroner and retired State Crime Laboratory director, died Wednesday, October 30, 1991. He was 74.

Dr. Holt was a member of the Arkansas Medical Society and the Fifty Year Club, the Pulaski County Medical Society, the American Medical Society, the American Society of Abdominal Surgery, and the Southwest Surgical Congress.

Survivors are his wife, Jim O'Lee Steele Holt; three sons, Michael B. Holt and Timothy J. Holt, both of Little Rock, and Dr. Douglas F. Holt of Baton Rouge, La.; a daughter, Lee Holt of Little Rock; a brother, Francis W. Holt of Dallas, Tex.; a sister, Mrs. James F. Head of McLean, Va.; and five grandchildren.

## **Earl Parsons, M.D.**

Dr. Earl Parsons, a retired psychiatrist from Arkadelphia, died Thursday, October 24, 1991. He was 75.

Survivors are his wife, Mary Pence Parsons; two sons, Capt. Pence Parsons of San Diego, Calif., and Patrick Parsons of Hot Springs; a daughter, Penny Parsons of Charlotte, NC; his mother, Mrs. Lillian Parsons of Buffalo, Wyo., a sister, Marianne Herzog of Billings, Mont., and three grandchildren.

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MULTI-USER ENVIROMNEN

NETWORKING

ACCEPT ASSIGNMEN

CROSSOVER CLAIM EDS

CHARGE SLIPS HMO WRITE-OFF

CURRENT PROCEDURAL TERMINOLOGY

OUTSIDE LAB CHARGES

SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER HICFA

PLACE OF SERVICE CODE

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILIAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING LEDGER CARDS WRITE-OFF

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DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT

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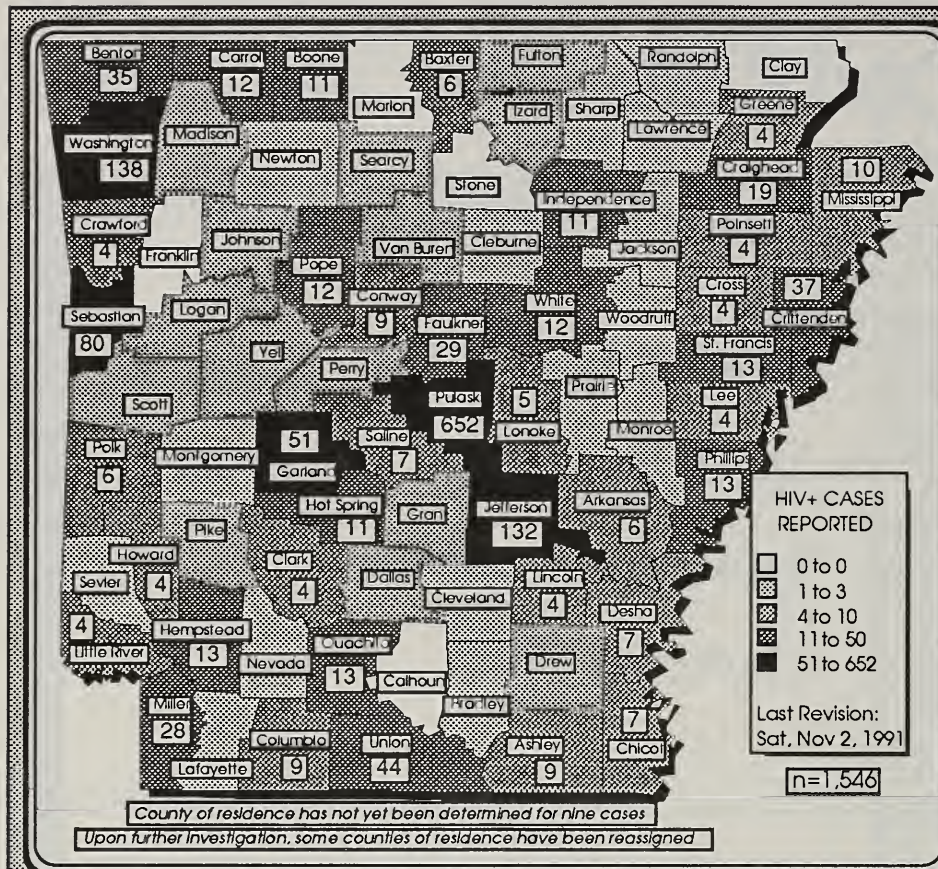
RESPONSIBLE PARTY

INDIVIDUAL POLICY NUMBER



# Arkansas AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

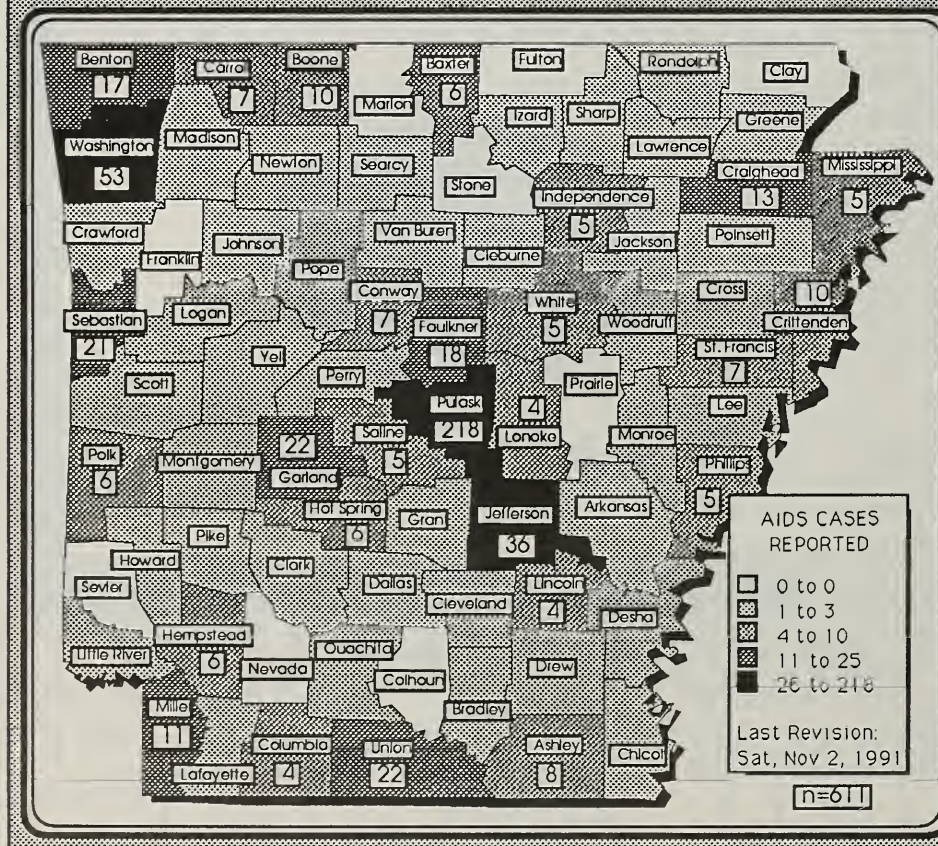
- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of: Nursing Homes, Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

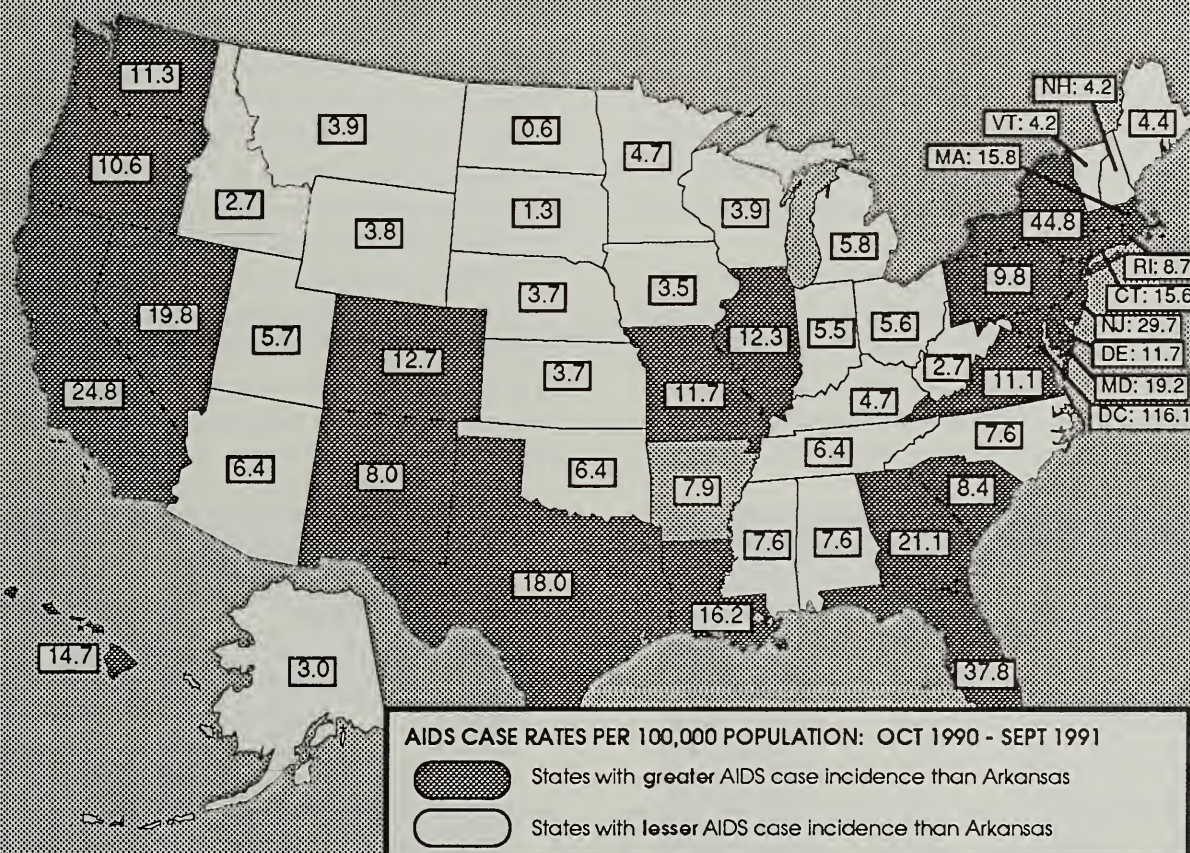




# Arkansas HIV/AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: OCT '90 - SEP '91	187	Reported: OCT '90 - SEP '91	43,744
Rates per 100,000 population: OCT'90 - SEP'91	7.9	Rates per 100,000 population: OCT'90 - SEP'91	17.2
Cumulative Reports: 1983 - OCT '91	611	Cumulative Reports: 1980 -SEP '91	195,718
Adult	595	Adult	192,406
Pediatric	16	Pediatric	3,312
Deaths: 1983 - OCT '91	346	Deaths: 1980 - SEP '91	126,159
Adult	340	Adult	124,380
Pediatric	6	Pediatric	1,779
Mortality Rate	56.6 %	Mortality Rate	64.5 %



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Men who have sex with men	61.7 %	Men who have sex with men	57.6 %
Heterosexuals who use IV Drugs	11.3 %	Heterosexuals who use IV Drugs	22.1 %
Men who have sex with men and use IV Drugs	9.7 %	Men who have sex with men and use IV Drugs	6.4 %
Heterosexual contact with person at risk	5.2 %	Heterosexual contact with person at risk	5.6 %
Transfusion with blood products	4.7 %	Transfusion with blood products	2.3 %
Infants born to HIV-infected mothers	2.1 %	Infants born to HIV-infected mothers	1.4 %
Persons with hemophilia	2.0 %	Persons with hemophilia	0.8 %
Risk unknown at this time	3.3 %	Risk unknown at this time	3.7 %



# Medicine in the News

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## Health Care Access Foundation Update

As of December 1991, the Arkansas Health Care Access Foundation has provided free medical services to 3,234 medically indigent persons.

The program has 1,464 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## Arkansas' Campaign for Healthier Babies

Arkansas' Campaign for Healthier Babies, a media program designed to increase the number of pregnant women who receive prenatal care, began in January 1991.

Addressing the infant mortality problem in the state of Arkansas is a priority in the Governor's office along with the Health Department. The director, Dr. Joycelyn Elders, has taken a head strong approach to this issue for the past four years.

"The infant mortality rate in Arkansas has dropped one point from 10.3 deaths to 9.3 deaths per 1,000 live births for 1989," Dr. Elders said. "Getting the word out about prenatal care through the campaign means the lives of babies will be saved and medical costs will be cut because there will be fewer babies born with problems."

The campaign is being implemented in three

phases - awareness, education, and incentive. The campaign's honorary chairmans is the states' first lady, Hillary Clinton. "The objectives are simple," says Mrs. Clinton, "One, to make Arkansas aware of the state's high infant mortality and low birthweight numbers and the negative implications of those statistics. Two, to educate Arkansas about what early prenatal care is. And three, to provide incentives for pregnant women that encourage them to seek early prenatal care."

Three television sponsors statewide are promoting the campaign through documentaries, television spots and public service announcements for each phase.

The unique sponsorship of the campaign is a coalition of the Arkansas Department of Health, the Department of Human Services, the Arkansas chapter of the March of Dimes, the University Hospital's Department of Obstetrics and Gynecology High Risk pregnancy Program, and Arkansas Advocates for Children and Families.

Other campaign tools are a speaker's bureau; toll free information line; *Babies and Your Business*, a report to industry emphasizing the positive aspects of prenatal care at the worksite; *Campaign Connection*, a newsletter; and a campaign video, *"Healthier Babies mean a Healthier Future for Arkansas."*

For more information about the campaign, call 1-800-235-0002.

## Northwest Arkansas Opportunity

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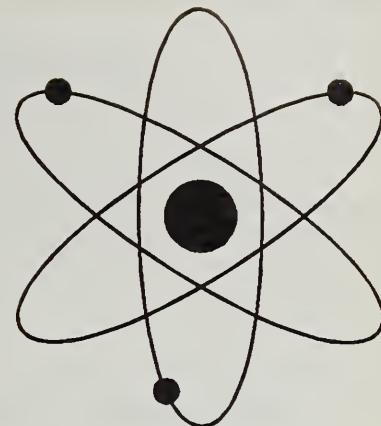
## Equipment For Sale

1984 Olympus OSF primary care sigmoidofiberscope with standard accessories and CLK-3 simplified light source. Comes with a hard case. Good condition. Call David Simmons at:

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# Radiological Case of the Month



Steven R. Nokes, M.D.  
Aniel House, M.D.  
Dale Fuller, M.D.  
David L. Harshfield, M.D.

## History:

This 84-year-old woman presented with increasing abdominal girth.

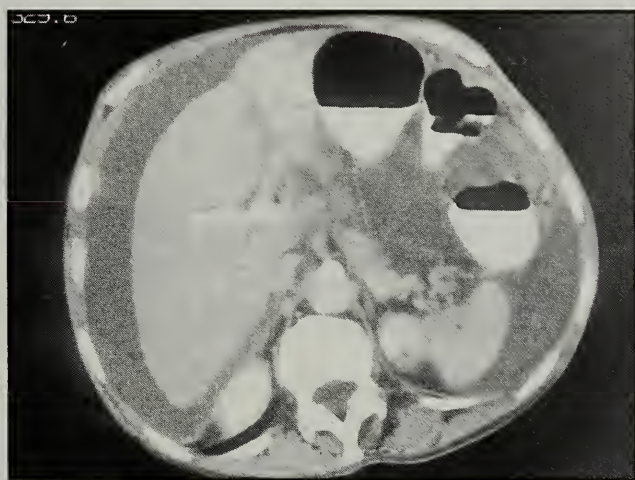


Figure 1. CT scan of the abdomen.



Figure 2. CT scan of the abdomen.



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# Omental Metastases

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## Radiographic Findings:

Both images demonstrate massive ascites. Figure two reveals the omentum to be extensively replaced by solid tumor (omental cake). This lies between the colon and the anterior abdominal wall.

## Discussion:

The greater omentum is formed from the anterior and posterior visceral peritoneum that covers the stomach. This double layered membrane drapes over the small bowel and colon, and folds back on itself to insert just above the transverse colon. The resultant four-layered structure defines the lesser sac, which seldom extends below the transverse colon secondary to adhesions.

Conventional radiography cannot image the omentum directly. Plain radiographs and barium studies occasionally suggest omental pathology indirectly. Ultrasound may detect large omental masses, but it is difficult to visualize small lesions. Subtle omental disease is easily visible on routine CT, although this may not be appreciated without critical evaluation.

Abnormalities of the omentum are easily demonstrated on the CT by replacement of normal omental fat by soft tissue. Most often this produces a "smudged" appearance. Omental caking (replacement of normal fat by large masses), as in this case is the next most common pattern. Cystic masses and multiple small discrete nodules are less frequently observed. Ascites is frequently present, and improves the sensitivity to associated peritoneal metastases.

The pattern of omental involvement is nonspecific and benign and neoplastic disease are indistinguishable. Accompanying abnormalities, such as hepatic metastases, adenopathy and peripancreatic inflammatory changes, can be helpful in this regard. Inflammatory disease is usually secondary to TB or pancreatitis. Neoplastic disease is more common and usually metastatic. Ovary, colon, stomach, liver, uterus, and breast are the most common primary sites.

## References

1. Cooper C, Jeffrey RB, Silverman PM, Federle MP, Chun CH. Computed tomography of omental pathology. JCAT 1986; 10:62-66.
2. Meyers MA, Oliphant M, Berne AS, Feldberg MAM. The peritoneal ligaments and mesenteries: pathways of intra-abdominal spread of disease. Radiology 1987; 163:593-604.
3. Buy JN, Moss AA, Ghossain MA, Sciort C, Malbec L, Vadrot D, Daniel BJ, Deriox Y. Peritoneal implants from ovarian tumors: CT findings. Radiology 1988; 169:691-94.

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*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Aniel House, M.D., is affiliated with the House Family Clinic in North Little Rock.*

*Contributor: Dale Fuller, M.D., is affiliated with the North Little Rock Women's Clinic.*



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# Things To Come

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## December 11

**Pediatric Transfusion Therapy Teleconference.**  
Sponsored by the American Association of Blood Banks. Fees: \$20.00, members; \$30.00 nonmembers. For more information, contact the AABB Department of Education at (703) 297-0522.

## January 24-25, 1992

**Transfusion Medicine 1992.** Arlington, Virginia and Los Angeles, CA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$190.00, members; \$240.00, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

## March 13-15

**19th Annual Scientific Meeting of the American College of Nuclear Medicine.** Sheraton New Orleans Hotel, LA. For more information, contact Thomas Johnson at (717) 898-6006.

## March 27-28

**Leukocyte Reduction and Blood Component Therapy.** Stouffer Concourse Hotel, Arlington, VA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$200, members; \$250, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

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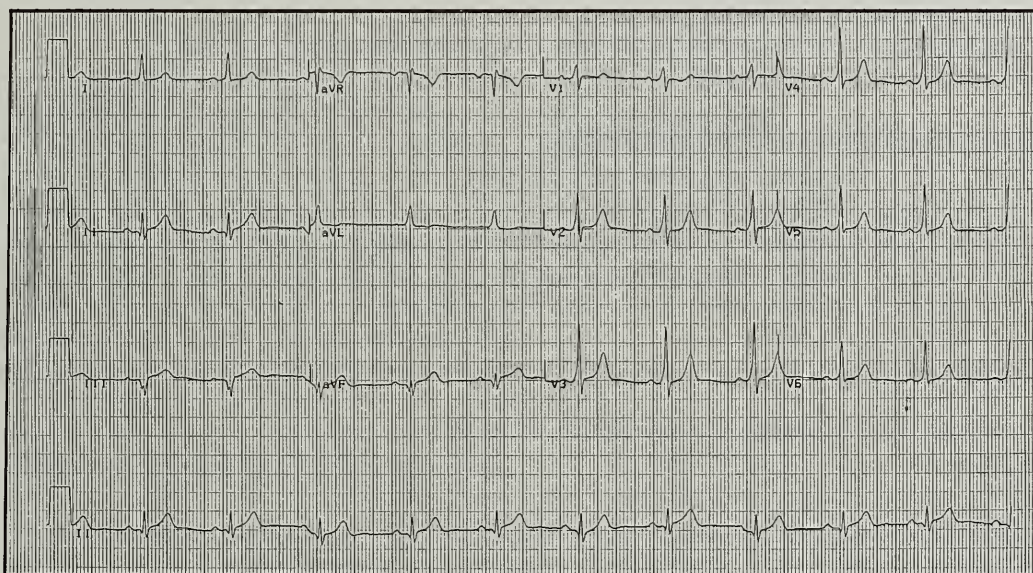


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## HISTORY:

This record was obtained from a 46-year-old male who presented to the Emergency Department complaining of chest pain. He stated that he had previously experienced an inferior myocardial infarction at another hospital in 1987. He also gave a history of multiple myeloma and chronic pain medicine ingestion.



## DISCUSSION:

Normal sinus rhythm is present with an apparent PR interval of 160 ms. Casual inspection of the ECG reveals what appears to be abnormal Q waves in the inferior leads (II, III, and aVF). This pattern suggests an old inferior infarction. However, several features suggest the correct diagnosis. First, the T waves are upright in the inferior leads. Old infarctions are generally, but not always, associated with flat or inverted T waves in the leads containing Q waves. Second, close inspection of the precordial leads, particularly V2-V5, reveal slurred upstroke preceding the R waves. These are delta waves and indicate the presence of ventricular pre-excitation. The delta waves are directed anteriorly and away from the feet, such that what appear to be Q waves in the inferior leads are in fact negative delta waves. Echocardiography revealed normal wall motion. The patient admitted to narcotic addiction and on further investigation was found to have visited other hospitals throughout the United States with a similar history.

Delta waves, along with a widened QRS and short PR interval comprise the diagnostic triad of the Wolff-Parkinson-White syndrome. However in this case, the PR interval is normal. Ventricular pre-excitation can also occur via Mahaim fibers, which course from the bundle of his to ventricular myocardium. AV nodal conduction is preserved, resulting in a normal PR interval. Similarly, the QRS duration is not widened because pre-excitation patterns more typical of Wolff-Parkinson-White may mimic either anterior or inferior Q waves as well.



# Keeping Up

---

## **Pediatric Gynecology**

*December 18, 12:00 noon, Sparks Regional Medical Center, 7th floor dining room. Sponsored by UAMS and presented by Karen Kozlowski, M.D. Fee: \$5.85. Category I credits available.*

## **Arkansas Hand Club Annual Meeting**

*May 8-9, 1992, Gaston's White River Resort, Lakeview. For more information, contact Nadine Gentry at the Arkansas Medical Society office at (501) 224-8967 or 1-800-542-1058.*

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark-Quapaw Room. One Category I credit per meeting.*

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
Medical Grand Rounds, Fridays, 12:00 noon, VAMC*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Dunkerton/AP&L room. Lunch provided  
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Pathology classroom. Lunch provided  
Cancer Center Team Conference, 3rd Thursday, 12:00 noon. Lunch provided  
Sleep Disorders Case Conference, every other Thursday, Video Production conference room. Lunch provided  
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon. Sandwich buffet served*

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1  
GI Conference, 4th Friday, 12:00 noon, call BMC at 227-2672 for location  
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library  
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided  
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided*

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category*



## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neruosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2



*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GRECC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## EL DORADO - AHEC

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## FAYETTEVILLE - AHEC NORTHWEST

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## FORT SMITH - AHEC

*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## JONESBORO-AHEC NORTHEAST

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th & 5th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## PINE BLUFF-AHEC

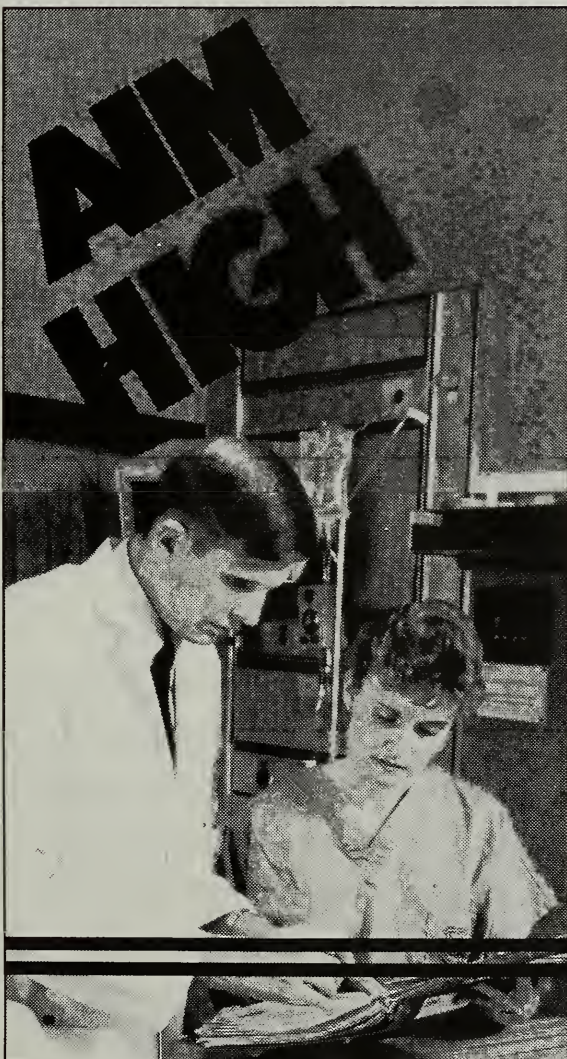
*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.



*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

## TEXARKANA-AHEC SOUTHWEST

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital



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Wright, William J.

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## **Desha County**

Go, Peter Kong Hua  
Harris, Howard R.  
Hoagland, Robert A.  
Masquil, Filipe  
Robinson, Guy U.  
Turney, Lonnie R.

## **Drew County**

Busby, Arlee K.  
Maxwell, Ralph M.  
McKiever, William R.  
Oxner, Troy Wayne  
Wallick, Paul A.  
Williams, William III  
Wilson, Harold F.



## Faulkner County

Archer, Charles A. Jr.  
Beasley, Margaret D.  
Benafield, Robert B.  
Bowlín, Randal  
Daniel, Sam V.  
Furlow, William C.  
Garrison, James S.  
Ghormley, Jonathan  
Gordy, L. Fred Jr.  
Hendrickson, Richard O. Jr.  
Hilman, Michael G.  
Holland, Rhonda  
Horton, Charles  
Jackson, Carole  
Landberg, Karl H.  
Magie, Jimmie J.  
Martin, David A.  
Marvin, Peter  
McCarron, Robert  
McChristian, Paul L.  
Murphy, Kenneth  
Pullman, Norman  
Shirley, David C.  
Smith, John D.  
Smith, Lander A.  
Stancil, Vicki  
Stone, Phillip  
Throneberry, Bart  
Wilson, Paul H.

## Franklin County

Gibbons, David L.  
Long, C. C.  
Smith, John C.  
Wilson, Robert

## Garland County

Arthur, James M.  
Aspell, Robert  
Atherton, Lee G.  
Atkinson, Robert H.  
Bandy, Preston R.  
Beamer, Lee F.  
Bodemann, Diane  
Bodemann, Michael C.  
Bodemann, Stephen L.  
Bohnen, Loren O.  
Borg, Robert V.  
Bracken, Ronald J.  
Braley, Richard E.  
Braun, James R.  
Brunner, John H.  
Bumpas, Timothy F.  
Burton, Frank M.  
Burton, James F.  
Campbell, James W.  
Cates, Jack A.  
Chamberlain, Joe W.  
Chu, Thomas  
Cofer, Thomas  
Cupp, Cecil W. III  
Davis, Sheryl L.  
Dembinski, T. Henry  
Dodson, John W. Jr.  
Dunn, Richard W.  
Durham, Thomas M. Jr. #  
Eisele, W. Martin  
English, P. Timothy  
Finan, E. Michael

Fore, Robert W.  
Fotioo, George J.  
French, James H.  
Gardial, J. Richard  
Gardner, James L.  
Garner, Onyx P. #  
Gocio, Allan C.  
Griffin, James E.  
Haggard, John L.  
Hale, Kevin D.  
Hansen, Dana  
Harper, Edwin L.  
Headrick, Daniel  
Hechanova, D. M. Jr.  
Heinemann, Fred M.  
Hill, Robert L.  
Hollis, Thomas H.  
Howe, H. Joe  
Hughes, James A.  
Humphreys, Robert P.  
Irwin, William G.  
Jackson, Haynes G.  
Jayaraman, K. K.  
Jayaraman, Vilasini D.  
Jayasundera, Naomal S.  
Johnson, Paulette S.  
Johnson, Robert D.  
Johnston, Gaither C.  
Kaler, Ron A.  
Keadle, William R.  
Kincheloe, A. Dale  
King, Leeman H.  
Kleinhenz, Robert W.  
Klugh, Walter G. Jr.  
Koehn, Martin A.  
Lang, Patricia A.  
Larrison, Charles A.  
Lee, William R.  
Lewis, Robert L.  
Lovell, Clarence R.  
Martin, Jana  
Maruthur, Gopakumar  
Mashburn, William R.  
McConkie, Stuart  
McCrary, Robert F. Jr.  
McFarland, Louis R.  
McMahan, James  
Meek, Gary N.  
Munos, Louis R.  
Newton, Doane M.  
Olive, Robert Jr.  
Pai, Balakrishna  
Pappas, Deno P.  
Parkerson, Cecil W.  
Peeples, Raymond E.  
Pellegrino, Richard  
Powell, Brenda  
Queen, George P.  
Rainwater, W. Sloan  
Reddy, Prabhakara K.  
Robert, Jon M.  
Robertson, Fred T.  
Rosenzweig, Joseph L.  
Russell, Mark  
Sanders, Hallman E.  
Schmidt, Clinton C.  
Seifert, Kenneth A.  
Shelby, Eugene M.  
Shroff, Rajesh K.  
Simpson, John B.  
Slaton, Catherine R.

Slaton, G. Don  
Slezak, James  
Smith, Bruce L. Jr.  
Smith, John  
Smith, Phillip L.  
Sorrels, John W.  
Springer, Melvin R. Jr.  
Springer, William Y.  
Stecker, Elton H. Jr.  
Stecker, Rheeta M.  
Stough, Dowling B. IV.  
Stough, Dowling Bluford III.  
Thomas, W. Al  
Thompson, Thomas P. Jr.  
Trieschmann, John W.  
Tucker, R. Paul  
Wallace, Thomas  
Walley, Luther R.  
Webb, Timothy  
Woodward, Philip A.  
Wright, Charles C.  
Wright, William J.

## Grant County

Irvin, Jack M.  
Paulk, Clyde D.

## Greene-Clay County

Anders, Ernest  
Baker, A. J.  
Baker, Clark M.  
Boggs, Dwight F.  
Bonner, J. Darrell  
Cagle, Roger E.  
Collier, George H. Jr.  
Crow, Asa A.  
Duckworth, Hillard R.  
Duplantis, Kathryn  
Futrell, Junius B. #  
Hardcastle, R. Lowell  
Harper, Bland  
Hazzard, Marion P.  
Hobby, George A.  
Kemp, Clarence  
Lawson, J. Larry  
Martin, Richard O.  
Mitchell, Bennie E.  
Muse, Jerry L.  
Page, Billie C.  
Purcell, Donald I.  
Rollins, William  
Sellars, John R.  
Shedd, Leonus L.  
Sheridan, James G.  
Shotts, C. Mack Jr.  
Shotts, Vern Ann  
Smith, Norman  
Watson, Samuel D.  
White, Robert B.  
Williams, Dwight M.  
Williams, Jacob M.

## Hempstead County

Branch, James W. Sr. #  
Harris, Lowell O.  
Holt, Forney G.  
McKenzie, Jim  
Portis, Richard P.  
Stevens, David G.  
Wright, George H.

## Hot Spring County

Bollen, A. Ray  
Brashears, Larry B.  
Burton, Bruce K.  
Cobb, Russell W.  
Ellis, C. Randolph  
Highsmith, Vivian F.  
Kersh, N. B.  
Lloyd, Gregory M.  
Peters, Claude F.  
Vaughan, John A.  
White, Bruce A.  
White, Robert H.

## Howard-Pike County

Dunn, Robert  
Floyd, Mark A.  
Gullett, A. Dale  
Humphreys, T. J. Jr.  
King, Joe D.  
Peebles, Samuel W.  
Sykes, Robert  
Turbeville, James O.  
Ward, Hiram T.  
White, Phillip L.

## Independence County

Alexander, William Steve  
Allen, James D.  
Baker, John R.  
Baker, Robert V.  
Baxley, Paul J.  
Beck, Carl T.  
Bess, Lloyd G.  
Brown, Hunter Lee  
Brown, Verona T.  
Davidson, Dennis O.  
Fowler, William  
Fulbright, Thomas  
Garst, Neema A.  
Goodin, William H. Jr.  
Hays, Sarah F.  
Jones, Edward J.  
Jones, Edward T.  
Ketz, Wesley J.  
Lambert, John S.  
Lytle, Jim E.  
McClain, Charles M. Jr.  
Moody, Lackey G.  
O'Brien, Marcus D.  
Piediscalzi, Nicholas  
Raney, W. Troy  
Scott, John G.  
Simpson, Ronald  
Slaughter, Bob L.  
Sloan, Fredric J. II  
Smith, Bob G.  
Stalker, James M.  
Strickland, Nathan E.  
Taylor, Chaney W.  
Taylor, Charles A.  
Tucker, Charles L.  
Waldrip, William J. III  
Walton, Robert B.  
Webster, Russell P.  
Zini, James E.

## Jackson County

Ashley, John D. Jr.  
Carney, J. W.



Chauhan, Mufiz A.  
 Cole, B. Eliot  
 Conrady, Rickie A.  
 Dudley, Guilford M. III  
 Falwell, K. Wade  
 Foote, John W.  
 Frankum, Jerry M. Jr.  
 Green, Roger L.  
 Hergenroeder, Paul J.  
 Jackson, Jabez Fenton Jr.  
 Junkin, A. Bruce  
 Poon, Hon K.  
 Reynolds, Roland C.  
 Williams, Thomas E.  
 Young, Jack S. III

### Jefferson County

Anderson, Charles W.  
 Anderson, Daphne  
 Anderson, Mark  
 Armstrong, Simmie Jr.  
 Atkinson, Evangelina  
 Atkinson, Robbie  
 Atnip, Gwyn  
 Attwood, H.  
 Bell, Carl H. Jr.  
 Bennett, Keith  
 Blackwell, Banks  
 Bracy, Calvin M.  
 Brooks, R. Teryl Jr.  
 Buckley, J. Wayne  
 Burford, Thomas G.  
 Burns, Robert E.  
 Busby, John  
 Butler, Robert C.  
 Campbell, James C. Jr.  
 Carlton, Irvin L.  
 Cheek, Ben H.  
 Crenshaw, John  
 Crowell, Kent  
 Davis, Charles M.  
 Dedman, John D.  
 Deneke, William  
 Duckworth, Thomas S.  
 Fendley, Ann E.  
 Fendley, Claude E.  
 Fendley, Herbert F.  
 Flowers, Martha A.  
 Forestiere, Lee A.  
 Freeman, William H.  
 Frigon, Gary F.  
 Frigon, Jacquelyn S.  
 Glasscock, Robert E.  
 Green, Horace L.  
 Gullett, Robert R. Jr.  
 Hardin, J. David  
 Harper, William F.  
 Hegwood, H. Melvin  
 Henderson, Francis M.  
 Hughes, L. Milton  
 Hussain, Shafqat  
 Hutchison, E. L.  
 Hyman, Carl E.  
 Irwin, Raymond A. Jr.  
 Jacks, David C.  
 Jacks, Dennis  
 James, William J.  
 Jenkins, Bobby  
 Jenkins, Mary Ellen  
 Joseph, Aubrey S.  
 Justiss, Richard D.

Khan, Mahmood A.  
 King, Yum Y.  
 Langston, Lloyd G.  
 Ligon, Ralph E.  
 Lim, William N.  
 Lindsey, James A.  
 Lum, Don  
 Lupo, David A.  
 Lytle, John O.  
 Mabry, Charles D.  
 Maynard, Ross E. #  
 McDonald, Robert L.  
 McFarland, Mike S.  
 Mehta, Shyam P.  
 Meredith, William R.  
 Miller, Donald L.  
 Milligan, Monte C.  
 Morris, Harold J.  
 Newan, Michael  
 Nixon, David T.  
 Nixon, William R.  
 Nuckolls, J. William  
 Pearce, Malcolm B.  
 Pierce, J. R. Jr.  
 Pierce, Reid  
 Pierce, Ruston Y.

Plaza, Jesus' A.  
 Rainey, William C.  
 Reid, Lloyene B.  
 Ridling, Anna T.  
 Roaf, Sterling A.  
 Robinette, Joseph S.  
 Rogers, Henry L.  
 Ross, Robert L.  
 Samuel, Ferdinand K.  
 Shorts, Stephen D.  
 Simmons, Calvin R.  
 Simpson, P. B. Jr.  
 Smith, Paul L.  
 Stern, Howard S.  
 Sullenberger, A. G.  
 Sweatt, John  
 Tanner, Ronald D.  
 Tisdale, Alfred D. Jr.  
 Toatley, Donald U.  
 Townsend, Thomas E.  
 Tracy, C. Clyde  
 Waheed, Atiya N.  
 Walajahi, Fawad H.  
 Washington, Erma  
 Wilkins, Walter J. Jr.  
 Wineland, Herbert L.  
 Worrell, Aubrey M. Jr.

### Johnson County

Pennington, Donald H.  
 Shrigley, Guy P.

### Lafayette County

Harbin, Bradley  
 Hutson, Sanford E. III  
 Lee, Willie J.

### Lawrence County

Hughes, Joe E.  
 Joseph, Ralph F.  
 Lancaster, Ted S.  
 Langley, Michael G.  
 Quevillon, Robert D.  
 Spades, Sebastian A. III

### Lee County

Balke, Susan W.  
 Fields, E. C.  
 Gray, Dwight W.  
 Ly, Duong N.

### Little River County

Armstrong, James  
 Dalby, Robert D.  
 Peacock, Norman W. Jr.  
 Shelton, Joseph Jr.

### Logan County

Alexander, Eugene  
 Buckley, Douglas A.  
 Chalfant, Charles  
 Daniel, William R.  
 Enns, Wayne P.  
 Harbison, James D.  
 Parker, Chuck  
 Roberts, William J.  
 Smith, James T.  
 Ulrich, Guy  
 Williams, John R.

### Lonoke County

Abrams, Joe A.  
 Anderson, Leslie  
 Chapman, Jerry C.  
 Elam, Garrett  
 Gartman, Joseph F.  
 Holmes, Byron E.  
 Inman, Fred C. Jr.  
 Schumann, Gerald M.  
 Washburn, C. Yulan

### Miller County

Alkire, Carey  
 Andrews, A. E. Jr.  
 Barnes, Walter C. Jr.  
 Blankenship, D. Michael  
 Brown, Sam F.  
 Burroughs, James C.  
 Collins, Stanley  
 Cummins, J. Craig  
 Cutler, Otis  
 Deskin, Roy L.  
 Desrochers, Paul E.  
 Dildy, Edwin V. Jr.  
 Ditsch, Craig E.  
 Dodd, N. Leland  
 Dodge, John M.  
 Duncan, Donald L.  
 Fisher, John  
 Fournier, Donald C.  
 Gabbie, Mark  
 Gillean, John A.  
 Graham, John  
 Green, R. Clark  
 Griffin, Nancy  
 Hall, Eric E.  
 Hall, Jon D.  
 Harrell, William B. Jr.  
 Harris, C. Lynn  
 Hillis, Thomas M.  
 Hodson, Gregory  
 Hughes, A. Keith  
 Hughes, R. Paul #  
 Hurley, James M.  
 Hutcheson, Fred A. Jr.

Jean, Alan B.  
 Jones, John W.  
 Joyce, Frederick E.  
 Kemp, Karlton H.  
 Kittrell, James  
 Knowles, Stanley C.  
 Leavelle, Ray W.  
 Loe, Arlis W.  
 McGinnis, Robert S. Sr.  
 Morris, Howard  
 Newton, Norris L.  
 Newton, Norris L. Jr.  
 Norris, John A.  
 Northam, Jon Mark  
 O'Banion, Dennis  
 Payne, Alvin  
 Peebles, Larry M.  
 Robbins, Joseph  
 Rountree, Glen A.  
 Royal, Jack L.  
 Sarrett, James  
 Schmidt, Howard  
 Shipp, G. Carl  
 Smith, Arnett D. Jr.  
 Solomon, J. Alan  
 Somerville, Patrick J.  
 Strickland, Glen  
 Stringfellow, Jerry B.  
 Thornton, Charles N.  
 Tompkins, William Jr.  
 Turnage, Richard H.  
 Vereen, Lowell E.  
 Wade, Billy  
 Warren, William Jr.  
 Wilhelm, Frieda  
 Wren, Herbert B.  
 Wright, James O. III  
 Yarbrough, Charles P.  
 Young, Mitchell

### Mississippi County

Abraham, Anes Wiley  
 Abramson, Lawrence  
 Bell, Mary C.  
 Biggerstaff, Jerry  
 Brock, Charles C. Jr.  
 Campbell, Charles E. Jr.  
 Cole, Cecil R.  
 Cullom, Sumner R.  
 Fairley, Eldon  
 Fergus, R. Scott  
 Hall, Leslie  
 Haynes, Max G.  
 Hester, Karen Calaway  
 Hester, Richard  
 Higley, George B. Jr.  
 Hubener, Louis F.  
 Hudson, James H.  
 Husted, G. Scott  
 Johnson, Jonathan H.  
 Jones, Herbert  
 Jones, Joseph V.  
 Lin, Ching-Shan  
 Melton, Clinton G.  
 Osborne, Merrill J.  
 Pollock, George D.  
 Rauls, Stephen R.  
 Rhodes, Joseph  
 Rhodes, R. F.  
 Rodman, T. N.  
 Russell, James D.



Shaneyfelt, E. A.  
Smith, Ronald D.

## Monroe County

Collins, Linda  
David, Neylon C. Jr.  
Pham, Dac Tat  
Pupsta, Benedict F.  
Stone, Herd E. Jr.  
Walker, Walter L.

## Nevada County

Vermont, Charles

## Ouachita County

Armato, Andrew A.  
Braden, Lawrence F.  
Brunson, Milton  
Crump, Mark  
Dedman, J. L. Jr.  
Dedman, William D.  
Floss, Robert  
Fohn, Charles H.  
Guthrie, James  
Hout, Judson N.  
Jameson, John B. Jr.  
Kendall, Jerry R.  
McFarland, Gale  
Miller, John H.  
Nunnally, Robert H.  
Ozment, L. V.  
Rayford, Cleveland  
Sanders, Cal R.  
Thorne, Arthur E.

## Phillips County

Barrow, John H. Jr.  
Bell, L. J. Patrick  
Bell, L. J. Patrick II  
Berger, Alfred A.  
Duensing, Theodore  
Epstein, S. Mitchell  
Faulkner, Henry N.  
Frederick, William Ronald  
Greening, Billy  
Kirkman, C. M. T.  
McCarty, Charles P.  
McCarty, Gordon E. Jr.  
McDaniel, Marion A.  
Miller, Robert D. Jr.  
Paine, William T.  
Patton, Francis M.  
Rangaswami, Narayanaswami  
Robirds, David Mark  
Tukivakla, P. Reddy  
Vasudevan, Kanaka  
Vasudevan, P.  
Wise, James E. Jr.

## Polk County

Finck, John Henry  
Fried, David D.  
George, Anthony D.  
Lochala, Richard  
McClard, Helen  
Mesko, John D.  
Page, M. Bryan  
Rogers, Henry N.  
Wood, John P.

## Pope County

Ashcraft, Ted  
Austin, Nathan  
Bachman, David S.  
Barron, William G.  
Barton, A. Dale  
Battles, Larry D.  
Beavers, Kevin  
Bell, Michael  
Bell, Robert A.  
Berner, Dennis W.  
Birum, Patricia J.  
Bost, R. Kingsley  
Bradley, Stanley C.  
Brown, Charles H.  
Burgess, James G.  
Callaway, Jody C.  
Carter, James M.  
Cloud, Joe A.  
Crumpler, Joe B. Jr.  
Dunn, Donald L.  
Galloway, William W.  
Gately, Stanley  
Haines, Lynn  
Harrison, Rick  
Hass, Farrell D.  
Hendren, Mike  
Henry, J. Arnold  
Hill, Donald F.  
Hollabaugh, Denise  
Honghiran, Ted  
Jones, Charles Jr.  
Kerin, Douglas  
Killingsworth, Stephen M.  
King, John W.  
King, W. Ernest Jr.  
Kolb, James M. Jr.  
Lawrence, Frank M.  
Lovell, Richard K. Sr.  
Lowrey, Douglas H.  
Lyford, Joe H. Jr.  
Malone, George E.  
Mauch, E. Jane  
May, Robert H. Jr.  
Meyer, Kelly H.  
Mobley, Max J.  
Monfee, Andrew M.  
Murphy, David S.  
Myers, J. Mark  
New, Kenneth O.  
Riddell, C. Michael  
Riley, Don C.  
Soto-Figueroa, Sergio F.  
Speed, Darrell  
Stinnett, Thomas  
Stolz, Gerald A. Jr.  
Teeter, Stanley D.  
Thurlby, W. Robert  
Turner, Finley P. II  
Turner, Kenneth B.  
Wilkins, Charles F. Jr.  
Williams, David M.  
Young, Sandra S.

## Pulaski County

Abbott, William W.  
Abel, Lee C.  
Abraham, James H.  
Abraham, Robert E.  
Adametz, James

Adametz, John  
Adamson, James  
Alexander, Albert S.  
Alford, T. Dale  
Allen, Durward Jr.  
Allen, John E. Jr.  
Allen, Thomas  
Alston, Phillip  
Aquino, Al  
Araoz, Carlos  
Armstrong, Howard  
Arnold, David  
Arrington, Robert  
Ashcraft, Keith #  
Atkinson, William Jr.  
Ault, Charles C. #  
Austin, R. Lee  
Autry, Daniel H. #  
Baber, John C. Jr.  
Baber, John T.  
Backus, Joe T.  
Bailey, H. A. Ted Jr.  
Baker, Glen F.  
Baker, John  
Baker, Johnson  
Baker, Yvette  
Baldwin, Maxwell R.  
Ball, Charles W. Jr.  
Ballard, Clarence E. Jr.  
Barber, Jeffrey  
Barclay, David  
Bard, David S.  
Barger, Denver L.  
Barlow, Brian E.  
Barnes, Reginald  
Barnes, Robert W.  
Barnett, David  
Barnett, Troy F.  
Barron, Edwin N. Jr.  
Barton, Gary  
Baskin, Barry  
Bates, Ramona  
Bates, Stephen  
Bates, Francisco  
Bauer, F. Michael  
Bauer, Frank M. Jr.  
Bauman, David C.  
Bayliss, John M.  
Beadle, Beverly  
Bearden, James R.  
Beaton, J. Neal  
Beck, Joseph II.  
Becquet, Norbert J.  
Beland, Susan S.  
Belknap, Melvin L.  
Bell, Rex H.  
Bennett, Eaton W.  
Bennett, F. Anthony Jr.  
Benton, William  
Berry, Frederick B.  
Berry, Robert L.  
Bevans, David W. Jr.  
Bienvenu, Gregory  
Billie, James  
Biondo, Raymond V.  
Birkett, Ian McRae  
Bishop, William B.  
Black, H. Thurston  
Blackshear, Jack L. Jr.  
Blankenship, William F.  
Blasier, R. Dale

Boehm, Timothy  
Boellner, Samuel W.  
Boger, James E.  
Bogost, Bruce  
Book, Lindy  
Boop, Warren C. Jr.  
Bornhofen, John H.  
Bost, Roger B.  
Bowen, William  
Bower, Charles M.  
Boyd, Charles M.  
Boyle, Ronald H.  
Bozeman, Barbara J.  
Bradburn, Curry B. Jr.  
Bradford, J. David  
Bradley, Joe F.  
Brainard, Jay O.  
Brenner, George H. Jr.  
Bressinck, Renie E.  
Brimberry, Ronald K.  
Brineman, John  
Brinkley, Roy A.  
Brizzolara, A. J.  
Brizzolara, John Paul  
Broach, R. Fred  
Brown, Michael  
Brown, Pamela  
Brown, Scott H.  
Brown, Steven L.  
Browning, Donald G.  
Browning, Stanley K.  
Brunson, Ashley  
Buchanan, Francis R.  
Buchanan, Gilbert A.  
Buchman, Joseph A.  
Buchman, Joseph K.  
Bucolo, Anthony P.  
Budhraj, Meenakshi  
Buford, Joe L.  
Bumpas, Joe H.  
Burger, Robert A.  
Burnett, Hugh F.  
Burnham, William W.  
Burrow, Dennis R.  
Byrd, Lucas M. Jr. #  
Byrum, Jerry  
Calcote, Robert A.  
Calhoon, J. Dale  
Calhoun, Joseph D.  
Calhoun, Richard A.  
Campbell, Gilbert S.  
Campbell, James W.  
Caplinger, Kelsy J. III  
Capps, Dwight II  
Carfagno, Jeffrey  
Carnahan, Robert G.  
Carson, Layne E.  
Carter, Jerry L.  
Carttar, Charles  
Caruthers, Samuel B. Jr.  
Casali, Robert E.  
Cash, Darlene  
Casper, Robert B.  
Cathey, Janet  
Cathey, Steven  
Cavin, Lillian  
Chakales, Harold H.  
Chandler, Billy M.  
Chappell, Carol W.  
Cheairs, David B.  
Cheairs, John T.



- Chisholm, Dan P.  
 Choate, Robert B.  
 Christeson, William W.  
 Christian, John D.  
 Chudy, Amail  
 Church, Marion M.  
 Church, Michael  
 Clark, J. Roger  
 Clark, Richard B.  
 Clift, Steven A.  
 Clifton, Cliff  
 Cobb, Jock S.  
 Cockrill, H. Howard Jr.  
 Cogburn, Bob E.  
 Colclasure, Joe B.  
 Collins, David  
 Cone, John  
 Cope, Michael  
 Corbitt, Mary  
 Cornell, Paul J.  
 Cornett, James K.  
 Cosgrove, Kingsley W. Jr.  
 Cosgrove, Lisa  
 Craig, Marion S. Jr.  
 Crawford, Cary M.  
 Crews, J. Travis  
 Crocker, Charles H.  
 Cross, J. B.  
 Crow, Joe W.  
 Crow, R. Lewis Jr.  
 Curtner, Byron D.  
 Davie, Melanie  
 Davis, Brett C.  
 Davis, Carole  
 Davis, Claudia  
 Davis, Glenn R.  
 Davis, J. Lynn  
 DeLoach, John Jr.  
 Dean, David M.  
 Dean, Gilbert O.  
 Deaton, C. William Jr.  
 Deer, Philip J. Jr.  
 Deer, Philip James III.  
 Dennis, James L.  
 Denson, William D.  
 DesLauriers, S. Killeen  
 Dickins, John R. E.  
 Dickins, Robert D. Jr.  
 Dickson, D. Bud  
 Dilday, James 'Kurt'  
 Dillard, Daniel C.  
 Diner, Bradley  
 Dixon, Keith A.  
 Dodd, Doyne  
 Doncer, Richard P.  
 Doucet, Marlon J.  
 Douglas, Warren M.  
 Downs, Ralph A.  
 Dungan, William T.  
 Dwyer, Gregory A.  
 Easley, Edgar J.  
 Easter, Rex M.  
 Edge, Otis H.  
 Edmiston, Frank G.  
 Eisenach, R. Jeffrey  
 Elders, M. Joycelyn  
 English, Jim  
 Evans, Billy  
 Evans, Scott J.J.  
 Eyre, Byron L.  
 Farmer, Joseph F.  
 Farque, Greg L.  
 Farris, Guy R. Jr.  
 Fazekas-May, Mary  
 Fernandez, Agustin  
 Ferris, Ernest J.  
 Fewell, Ronald D.  
 Fielder, Charles R.  
 Fields, Patrick R.  
 Finan, Barre F.  
 Fincher, Robert L.  
 Finkbeiner, Alex E.  
 Fiser, Martin  
 Fiser, Robert H. Jr.  
 Fiser, William P. Jr.  
 Fisher, Robert A.  
 Fitzgerald, Charles  
 Fitzhugh, A. Stuart  
 Flack, James V. Jr.  
 Flanigan, Stevenson  
 Flanigan, William  
 Fletcher, Anthony  
 Fletcher, Elizabeth D.  
 Fletcher, Thomas M.  
 Florez, James P.  
 Flowers, William C.  
 Floyd, Bill G.  
 Fraiser, Lacy P.  
 France, Gene L.  
 Fraser, Eric A.  
 Fraser, James H. Jr. #  
 Frazier, Cynthia  
 Frazier, G. Thomas  
 Fuller, C. Dale  
 Fuller, C. James III  
 Fulmer, John M.  
 Galbraith, Robert C.  
 Gardner, Guy F.  
 Gettys, Joseph M. Jr.  
 Gibbs, Mark  
 Gibson, Gordon L.  
 Giglia, Anthony R. III  
 Giles, Wilbur M.  
 Gillespie, A. Tharp  
 Gillespie, James  
 Gilliam, David  
 Gist, Charles C.  
 Glenn, Wayne B.  
 Glidden, Michael L.  
 Glover, Lawson E. Jr.  
 Glover, W. Clyde  
 Golden, William E.  
 Good, Henry H.  
 Gordon, Vida H.  
 Gosser, Bob L.  
 Goza, George M. Jr.  
 Graham, G. Grimsley #  
 Granger, William III  
 Grant, Karen G.  
 Gray, Edwin F. #  
 Green, William O. III  
 Greenway, C. Don  
 Greer, G. Stephen  
 Greutter, John E. Jr.  
 Grimes, H. Austin  
 Growdon, James H.  
 Guggenheim, Frederick G.  
 Guin, Jere D.  
 Gustavus, John L.  
 Hagans, James II  
 Hagler, James L.  
 Hahn, Herbert  
 Hall, A. D.  
 Hall, A. David  
 Hamilton, George Jr.  
 Hampton, John R. III  
 Hankins, Edwin III  
 Harber, Harley  
 Hardberger, R. E.  
 Hardin, Ronald D.  
 Harger, C. Harold  
 Hargrove, Joe L.  
 Harper, Ernest H.  
 Harper, Gary E.  
 Harrendorf, Cagle  
 Harrington, Mariann  
 Harris, Donald R.  
 Harris, Frances  
 Harris, T. Stuart  
 Harris, W. Turner  
 Harrison, A. Vale  
 Harrison, Roy E.  
 Harrison, William  
 Harshfield, David Lee Jr.  
 Hawley, Harold B.  
 Hayden, William F.  
 Hayes, J. Harry Jr.  
 Hayes, John  
 Hayes, Richard L.  
 Hayes, Sidney P.  
 Haynes, W. Ducote  
 Headstream, James W.  
 Hearnberger, H. Graves III  
 Hearnberger, Henry G. Jr.  
 Hedges, Harold I.V.  
 Hedges, Harold H.  
 Hefley, Bill F.  
 Hefley, William Jr.  
 Henker, Fred O. III  
 Henry, C. Reid Jr.  
 Henry, Charles R. Sr.  
 Henry, D. Andrew  
 Henry, G. Morrison  
 Henry, Guy  
 Henry, J. Charles  
 Henry, J. Forrest Jr.  
 Henry, Richard Y.  
 Henry, Robert L. Jr.  
 Henry, William T.  
 Henson, Gregory N.  
 Herron, Jerry M.  
 Herron, John T.  
 Hickey, Joseph P.  
 Hicks, David  
 Hicks, David  
 Hixson, Marcia Lynn  
 Hnilica, Violette E.  
 Hodges, J. Timothy  
 Hodges, Steven C.  
 Hoffmann, Thomas H.  
 Holland, Jay D.  
 Hollenberg, Henry G.  
 Holloway, J. Douglas  
 Holmes, Harlan C.  
 Holt, L. Gordon #  
 Holt, Stephen  
 Holton, Jerry C.  
 Hough, Aubrey J. Jr.  
 Houk, Richard  
 Houston, Samuel  
 Howell, Coburn S. Jr.  
 Howell, Marsha T.  
 Hudson, Thomas F. III  
 Hughes, Ronald D.  
 Hundley, John M.  
 Hundley, Randal F.  
 Hutchins, Steven W.  
 Hutchison, George R.  
 Hutson, Harold G.  
 Jackson, J. Presley  
 Jackson, Morris A.  
 Jackson, Thomas  
 Jansen, G. Thomas  
 Jefferson, Terry  
 Johnson, Anthony D.  
 Johnson, B. Richard  
 Johnson, Ben D.  
 Johnson, Carl  
 Johnson, Dianne Flowers  
 Johnson, Henry D.  
 Johnson, M. Bruce  
 Johnson, Philip H.  
 Johnston, Dale E.  
 Jones, Garry L.  
 Jones, John C.  
 Jones, Kathleen C.  
 Jones, Robert D.  
 Jones, Roy  
 Jones, William N.  
 Jordan, F. Richard  
 Jordan, Randy A.  
 Joseph, Ralph F. II  
 Joseph, William Frank  
 Jouett, W. Ray  
 Joyce, John W.  
 Junkin, Ruth H.  
 Kaemmerling, Raymond E.  
 Kahn, Alfred Jr.  
 Kane, Francis Jr.  
 Kane, James J.  
 Keathley, Susan A.  
 Keeran, Michael G.  
 Kellar, Stanley L.  
 Keller, Alford W.  
 Kennedy, Charles H.  
 Kennedy, Eleanor E.  
 Kennedy, H. Frazier  
 Key, J. Michael  
 Kilgore, Reed W.  
 King, Michael T.  
 King, William D.  
 Kirchner, Jeffrey  
 Kittler, Fred J.  
 Kizziar, Jim C.  
 Klein, E. F. 'Bud' Jr.  
 Klimberg, V. Suzanne  
 Knott, Patricia A.  
 Knox, Michael F.  
 Kolb, Agnes J.  
 Kolb, W. Payton  
 Koonce, Thomas W.  
 Kovaleski, Thomas M.  
 Kozberg, Oscar  
 Kramer, Thomas  
 Kramm, Paul C.  
 Krulin, Gregory S.  
 Kumpuris, Andrew G.  
 Kumpuris, Dean  
 Kumpuris, Frank G.  
 Kuykendall, R. Craig  
 Kyle, Joan E.  
 Kyser, James F.  
 Laakman, Robert W.  
 Lambert, Robert A.



Landers, James H.	Miles, David A.	Phillips, Hannah	Shuffield, James
Landgren, Robert C.	Miller, Forrest B. Jr.	Phillips, James R.	Silvoso, Gerald R.
Lane, John W.	Miller, Raymond P. Sr.	Pickett, Karen	Simmons, Orman W.
Lang, Nicholas P.	Milner, E. L.	Pierce, William	Simpson, N. Henry Jr.
Langston, Harold D.	Mitchell, George K.	Pike, John D.	Sims, James M.
Laurenzana, Donald A.	Mizell, Philip	Pledger, Norman R.	Singer, Peter
Lawson, Mason G.	Mizell, Walter S.	Pollard, Arlee E.	Singleton, L. Gene
LeNarz, LeRoy A.	Moffett, Robert Jr.	Pope, Norton A.	Sinor, Elicia
Lehmberg, Robert W.	Money, Wandal D.	Porter, Robert Jr.	Sipes, Frank M.
Leibovich, Marvin	Mooney, Donald K.	Potts, Jerry L.	Skokos, C. Kemp
Leonard, Donald G.	Moore, Burton A.	Power, Robert C.	Slater, John G. Jr.
Leou, Frank J.	Moore, J. Malcolm Jr.	Prather, Jerry L.	Slaven, John E.
Lester, Roger	Moore, Michael	Price, Ben O.	Slayden, John E.
Lewis, Derek	Moore, Rex N.	Pringos, Andrew A.	Sloan, Fay M.
Lewis, W. Sexton	Moore, Robert B.	Purdy, Harold D.	Sloan, James M.
Lile, Henry A.	Moore, Thomas	Pyle, Hoyte R. Jr.	Smart, Douglas F.
Lincoln, Ben M.	Morris, Barbara	Quirk, J. Gerald	Smelz, Johnny
Lipke, Jay M.	Morris, Paula	Ransom, John M.	Smith, Aubrey C.
Loebl, Edward C.	Morris, W. Dale	Raque, Carl J.	Smith, Charles Jr.
Logan, Charles W.	Morrison, Debra F.	Rector, Nancy F.	Smith, David E.
Love, Tommy L. Jr.	Morrison, Lynn	Reding, David L.	Smith, Douglas B.
Lowe, Betty A.	Morse, James C.	Redman, John F.	Smith, G. Richard Jr.
Lucy, Dennis D. Jr.	Morton, William J.	Reed, Ewing C. Jr.	Smith, James L.
Ludwig, Frank R.	Mulhollan, James S.	Reese, William G.	Smith, Mose III
Lyons, Virgle E. Jr.	Mundie, J. Ryland	Regnier, George G.	Smith, Purcell Jr.
Mabrey, William	Murphy, Bruce	Reid, Gene W.	Smith, Thomas J.
Magie, Stephen K.	Murphy, James E. Jr.	Remmel, Raymond	Smith, Thomas W.
Malak, F. A.	Murphy, Joseph	Rice, Charles	Smith, Tom
Mallory, John A.	Murphy, Randolph	Rice, James Curtis	Somers, A. Jack
Maloney, F. Patrick	Murphy, Robert	Riddle, John F. Jr.	Sorrells, R. Barry
Maners, Ann	Murphy, Tena	Riegler, N. W. Jr.	Sotomora, Ricardo F.
Mann, R. Jerry	Nagel, Fred G.	Riley, William H.	Squire, Arthur E. Jr.
Markland, Gary S.	Nash, John C.	Ritchie, Robert Ross	St Amour, Thomas E.
Marks, Stephen R.	Nelson, Alvah J. III	Robbins, Kenneth	Stair, J. Michael
Martin, Kenneth A.	Nelson, Carl L.	Roberson, Michael C.	Stallings, Walt
Martin, Richard H.	Nestrud, Richard M.	Rodgers, C. Dudley Jr.	Stanley, Joe P.
Martin, Robbie	Newsum, Jon Kirby	Rodgers, Charles H.	Stanton, T. Michael
Martinez, Luis	Newton, Fred E.	Rooney, Thomas P.	Steele, William L.
Mason, J. Zachary	Nix, Richard A.	Rosenbaum, Carl A.	Stefans, Vikki Ann
Mason, William L.	Nokes, Steven	Ross, Ashley Sloan	Stephens, Wanda
Matthews, Joseph W.	Nolen, James E.	Ross, Cynthia	Stern, Scott Jeffrey
Matthews, Robert R.	Norton, George A.	Ross, Robert W.	Sternberg, Jack J.
McAdoo, Hosea W. Jr.	Norton, Joseph A.	Ross, S. William	Stiles, Teresa
McCarthy, Richard E.	O'Neal, Walter H.	Rothert, Frances C.	Stone, Van D.
McConnell, John D.	Oates, Gordon P.	Rounsaville, Harry L.	Storeygard, Alan R.
McCracken, Gail Ann	Oddson, Terrence A.	Rouse, Lucien Jr.	Stotts, John R.
McCracken, John	Ogden, Mahlon D.	Roy, F. Hampton	Stout, Kimber
McCrary, George A.	Oglesby, Walter R.	Ruggles, Dwayne L.	Strauss, Mark
McCutcheon, Frank B. Jr.	Osam, Patrick N.	Runyan, William A.	Strode, Steven W.
McDonald, James E.	Osteen, Paul	Rutledge, William L.	Stroope, George F.
McDonald, Judy	Owings, Debra	Saer, Edward H. III	Studdard, James D.
McDonald, William Glen	Owings, Richard	Saltzman, Ben N.	Sturdivant, Stephen
McGowan, Robert Jr.	Ozment, Kerry	Sanderson, Marvin	Suen, James
McGrew, Robert N.	Padberg, Frank T.	Satre, Richard W.	Suliman, J. Samir
McKelvey, K. David	Paddock, George	Satterfield, John V. III	Sullivan, Charles D.
McKinney, Carl	Padilla, Fernando	Schlicht, Lisa	Sullivan, Jan R.
McKnight, C. Allen	Pahls, Wendell Lee	Schock, Charles C.	Sundermann, Richard H.
McMillin, F. Lamar Sr.	Pappas, James J.	Schratz, Bruce E.	Swindoll, Bryant S.
McNair, James R.	Parker, J. Mayne	Schroeder, George T.	Tabor, Marcella A.
McNee, Valerie	Parkhurst, James	Schultz, John C.	Talbert, Michael
Meacham, Donald F.	Parks, Greta	Schwander, L. Howard	Tamas, David E.
Meador, Annette Parker	Parnell, Clifton L. III	Scruggs, Jan W.	Tanner, James A.
Meadors, Frederick	Paulus, Thomas E.	Searcy, Robert M.	Taylor, David R.
Means, Paul N.	Pearce, Charles	Seibert, Joanna J.	Taylor, Eugene H.
Medlock, Rickey	Peeples, R. Earl	Seibert, Robert	Tedford, John G.
Mellor, Roy II	Peters, John E.	Selakovich, Walter G.	Teplick, Steven
Mendelsohn, Lawrence A.	Peters, Phillip J.	Shannon, Robert F.	Texter, E. Clinton Jr.
Metrailler, James A.	Petursson, Gissur J.	Sheppard, Joseph	Thomas, A. Henry
Meziere, Tom	Pevahouse, Joe	Shock, John P.	Thomas, Jerry L.
Middaugh, Riley Ann	Phillips, Bert L.	Short, Harold K.	Thomas, Kathy
Miers, Jane F.	Phillips, Charles E.	Shotts, Joseph	Thomas, Peter O.



Thompson, A. Reed  
 Thompson, John R.  
 Thompson, S. Berry Jr.  
 Thompson, Steven M.  
 Thorn, G. Max  
 Towbin, Eugene J.  
 Tracy, Phillip A.  
 Trantum, Bill L.  
 Tressler, Samuel D. III  
 Trussell, Thomas W.  
 Tseng, Jyi-Ming  
 Tucker, R. Stephen  
 Tucker, W. Everett  
 Valentine, Robert G. Jr.  
 Vaughter, W. Roger  
 Velez, Duane  
 Vinsant, Kurtis  
 Vogel, Robert G.  
 Wade, William I. Jr.  
 Wagoner, Jack  
 Walker, Ronald  
 Walt, James R.  
 Waner, Milton  
 Ward, Harry P.  
 Ward, Thomas  
 Warford, Walton R.  
 Warren, Emory  
 Watkins, Charles J.  
 Watkins, John Jr.  
 Watkins, John G. III  
 Watkins, Larry S.  
 Watson, C. Robert  
 Watson, Charles  
 Watson, Daniel W.  
 Watson, Vye B.  
 Weber, Edward R.  
 Weber, James R.  
 Weber, Michael  
 Weiss, David W.  
 Weiss, Gerald N.  
 Welch, Samuel Bradley  
 Wellborn, James C. Jr.  
 Wellons, James A. Jr.  
 Wende, Raymond A.  
 Wenger, Carl E.  
 Westbrook, Kent C.  
 Westerfield, Frank M. Jr.  
 White, Oba B.  
 Wilkes, Elbert H.  
 Wilkes, T. David I.  
 Williams, Alonzo D.  
 Williams, C. David  
 Williams, G. Doyne Jr.  
 Williams, Paul E.  
 Williams, Ronald N.  
 Williamson, Arian III  
 Wills, Pamela  
 Wilson, Elaine  
 Wilson, Frances C.  
 Wilson, Frank J. Jr.  
 Wilson, I. Dodd  
 Wilson, James W.  
 Wilson, John L.  
 Wilson, R. Sloan  
 Winburn, Mary B.  
 Wirthlin, Laurie Sue  
 Wolverton, John  
 Wong, Ting C.  
 Wooten, Virgil  
 Workman, W. Wayne  
 Wortham, Thomas H.

Wright, Ruel N.  
 Wyatt, Richard A.  
 Yamauchi, Terry  
 Yocum, John  
 Young, Douglas E.  
 Zelnick, Paul

### Randolph County

Baltz, Albert L.  
 Baltz, Mark  
 Barre, Hal S.  
 DeClerk, Thomas  
 Holt, Danny B.  
 Jansen, Andrew J. III  
 Mize, James S.  
 Murrey, James F.  
 Scott, William W.  
 Smith, Norman K.  
 Smoot, John D.

### Saline County

Ashby, John W. #  
 Ashby, Robert  
 Baber, Quin M.  
 Bethel, James  
 Burton, Charles R.  
 Caldwell, David L.  
 Cash, Ralph D.  
 Coker, S. Dale  
 Cooper, James B.  
 Cornwell, Samuel L.  
 Council, Robert A. Jr.  
 Dockery, Melissa  
 Duncan, J. Shelby  
 Eaton, James M.  
 Gardner, Dan R.  
 Hill, Edward B.  
 Hill, Howell V.  
 Hogue, F. Paul  
 Hood, C. Ted  
 Izard, Ralph S. Jr.  
 Johnston, Greg  
 Kirk, Marvin N. Jr.  
 Martindale, J. L.  
 Martindale, Mark A.  
 Ramsay, Rex C. Jr.  
 Smith, Robert  
 Stewart, David L.  
 Sudderth, Brian F.  
 Taggart, Sam D.  
 Thibault, Frank G. Jr.  
 Thomas, Bill R.  
 Thorn, Harvey Bell Jr.  
 Tilley, Roger L.  
 Viner, Donald L.  
 Wagner, Taylor  
 Watson, Kirk D.  
 Wright, John D.

### Sebastian County

Acklin, Jimmy D.  
 Albers, David G.  
 Alberty, Joe  
 Anderson, Paul  
 Atkins, Jimmie G.  
 Axelsen, Nils K.  
 Bailey, Charles W.  
 Baker, Max A.  
 Ballard, Robert L.  
 Barker, Robert Jr.

Barr, Marilyn  
 Barry, James Jr.  
 Beachy, Allen L.  
 Bell, Timothy  
 Berryhill, Richard E.  
 Berumen, Mike  
 Bordeaux, Ronald A.  
 Bouton, Michael  
 Bradford, A. C.  
 Brown, Byron L.  
 Brown, James A.  
 Brown, Richard  
 Buie, James H.  
 Builteman, James  
 Burks, Deland  
 Burt, William J.  
 Busby, J. David  
 Cain, Martin  
 Carson, Randall L.  
 Carter, D. Mike  
 Cassady, Calvin R.  
 Chambers, Donald  
 Cheshier, James L.  
 Chester, Robert L.  
 Cheyne, Thomas  
 Coffman, Edwin L.  
 Coleman, Michael D.  
 Craft, Charles  
 Crow, Neil E. Sr.  
 Crow, Neil E. Jr.  
 Culp, William C.  
 Daily, Richard  
 Davenport, O. Leo  
 Deaton, John M.  
 Deneke, James S.  
 Dorzab, Joe H.  
 Drolshagen, Leo F. III  
 Dudding, William F.  
 Edwards, Gary  
 Ellis, Homer G.  
 Ennen, Randy  
 Everett, Karen  
 Faier, Samuel  
 Feder, Frederick P. Jr.  
 Feezell, Randall E.  
 Feild, T. A. III  
 Felker, Gary V.  
 Ferrell, Jeffrey  
 Fisher, Robert D.  
 Flippin, Tony A.  
 Floyd, Charles H.  
 Francis, Darryl R. II  
 Franz, F. Perry  
 Gamble, Cory  
 Gedosh, Edgar A.  
 Gill, James A.  
 Girkin, R. Gene  
 Glover, D. Bruce  
 Goodman, R. Cole Jr.  
 Goodman, Raymond C. Sr.  
 Graves, Stephen C.  
 Griggs, William L. III  
 Gwartney, Michael P.  
 Hanley, Larry L.  
 Harmon, Pamela  
 Hathcock, Alfred B.  
 Heim, Stephen  
 Hendrickson, Jon  
 Hendrickson, Kathryn Denise  
 Henry, James  
 Herren, Adrian L.

Hewett, Archie L.  
 Hinkle, Richard A. Jr.  
 Hoffman, John D.  
 Hoge, Marlin B.  
 Holman, William A.  
 Holmes, Williams C. Jr.  
 Hornberger, Evans Z. Jr.  
 Howell, James T.  
 Hughes, Robert P. Jr.  
 Hunton, David W.  
 Hunton, Teresa H.  
 Huskison, William T.  
 Hyde, Marshall L.  
 Ingram, Ralph N.  
 Irwin, Peter J.  
 Jagers, Robert  
 Janes, Robert H. Jr.  
 Jefferson, Christina M.  
 Jefferson, Thomas C.  
 Jones, W. Duane  
 Kalec, John M.  
 Kareus, John L.  
 Kelly, Thomas C.  
 Kelsey, J. F.  
 Kennedy, Virgil N. #  
 Kientz, John Jr.  
 Klopfenstein, Keith  
 Knight, William E.  
 Knubley, William A.  
 Kocher, David B.  
 Koenig, A. Samuel III  
 Koenig, Albert S. Jr.  
 Kradel, R. Paul  
 Kramer, Ralph G.  
 Kutait, Kemal E.  
 Lambiotte, Louis O.  
 Landherr, Edwin  
 Landrum, Annette V.  
 Landrum, Samuel E.  
 Lane, Charles S. Jr.  
 Lange, John L.  
 Lenington, Jerry O.  
 Lewing, Hugh S.  
 Lilly, Ken E.  
 Lockhart, William G.  
 Lockwood, Frank M.  
 Long, James W.  
 MacDade, Albert D.  
 Magness, Jack L. Jr.  
 Manus, Stephen C.  
 Martimbeau, Claude  
 Martin, Art B.  
 Martin, Rick  
 Marvin, Michael  
 Masri, Hassan M.  
 McClain, Merle  
 McClanahan, J. David  
 McCraw, Gordon  
 McEwen, Stanley R.  
 McKinney, Robert  
 McMinimy, Donald  
 Meador, Don M.  
 Miller, Robert C.  
 Mings, Harold H.  
 Moulton, Everett C. Jr.  
 Moulton, Everett C. III  
 Mumme, Marvin E.  
 Murphy, Anne L.  
 Muylaert, Michel  
 Nassri, Louay  
 Nelson, Steve B.



Nichols, David R.  
 Niemann, Jeffrey M.  
 Nolewajka, Andre J.  
 Olson, John D.  
 Paris, Charles H.  
 Parker, Douglas W. Jr.  
 Parker, Thomas G.  
 Patrick, Donald L.  
 Pearce, Larry W.  
 Peluso, Francis  
 Pence, Eldon D. Jr.  
 Phillips, Don  
 Phillips, Kevin Clark  
 Phillips, Sumer  
 Phillips, W. P.  
 Pillstrom, Lawrence G.  
 Poe, McDonald Jr.  
 Poole, M. Louis  
 Pope, John R.  
 Post, James M.  
 Prewitt, Taylor A.  
 Price, Lawrence C.  
 Rabideau, Dana P.  
 Raby, Paul L.  
 Raymond, Thomas H.  
 Rivera, Raul  
 Robinson, Ronald P.  
 Rosenzweig, Kenneth  
 Russell, Rex D.  
 Sadler, John  
 Saviers, Boyd M.  
 Schemel, William H.  
 Schwarz, Julio  
 Schwarz, Paul R.  
 Sherman, Robert L.  
 Sherrill, William M. Jr.  
 Smith, Herbert T.  
 Smith, Kent  
 Smith, Terrald J.  
 Snider, James R.  
 Standefer, J. Michael  
 Stanton, William B.  
 Steinsiek, J. Bill II.  
 Steward, Rodney Jr.  
 Stewart, Jerry R.  
 Stewart, John B.  
 Still, Eugene F. II  
 Stillwell, Mark  
 Studt, James  
 Swicegood, John R.  
 Taft, Eileen  
 Taft, Eric  
 Tait, Amy  
 Tait, Layne  
 Thompson, J. Kenneth  
 Thompson, Robert J.  
 Trent, Judy  
 Turner, William F.  
 Van Asche, Christopher  
 Vanderpool, Roy E.  
 Vernon, Rowland P. Jr.  
 Waack, Timothy  
 Wahman, Gerald E.  
 Wallace, Kenneth K.  
 Webb, William K.  
 Weisse, John J.  
 Wells, John D.  
 Westbrook, Michael R.  
 Westermann, Norman F.  
 White, J. Earle III  
 Whiteside, Edwin

Wikman, John H.  
 Williams, Carl L.  
 Wills, Paul I.  
 Wilson, James M.  
 Wilson, Morton C.  
 Wilson, Steven K.  
 Wolfe, Michael S.  
 Woods, Leon P.  
 Zufari, Munir M.

### Sevier County

Hoyt, Jonathan  
 Jones, Charles N.  
 Mielnick, Alina

### St. Francis County

Burnette, David Sr.  
 Collins, E. Morgan Jr.  
 Conner, George  
 Crawley, Charles E.  
 DeRossitt, James P. III  
 Fong, Fun Hung  
 Hammons, Edward P.  
 Lopez, Ramon E.  
 McGuire, Samuel A. III  
 Meredith, James Jr.  
 Schwartz, Frank R.

### Tri-County County

Allen, Lewis  
 Arnold, Carl  
 Arnold, Griffin II.  
 Benton, Thomas H.  
 Bozeman, Jim G.  
 Campos, Louis  
 Ducker, David E.  
 Grasse, A. Meryl  
 Grasse, John Jr.  
 Heise, Lawrence F.  
 Jackson, George W.  
 Kearns, Harry  
 Krygier, Albin J.  
 Lane, Robert C.  
 Moody, Michael N.  
 Pembroke, Richard  
 Plemmons, Lloyd H.  
 Relyea, William V.  
 Smith, James F.  
 Tatum, Harold M.  
 Wright, Donald

### Union County

Barenberg, Robert  
 Bass, Edward J.  
 Bevill, Gary L.  
 Booker, J. Gregory  
 Bowman, Raymond N.  
 Callaway, James C.  
 Carroll, Peter J.  
 Cyphers, Charles D.  
 Dougherty, Bert  
 Dunn, Tom L.  
 Duzan, Kenneth R.  
 Elliott, Wayne G.  
 Ellis, Jacob P.  
 Fitch, Leston E.  
 Flournoy, Durwood W.  
 Forward, Robert B.  
 Fraser, David B.  
 Giller, W. John Jr.

Hardin, A. Scott  
 Hartmann, Ernest R.  
 Hill, Grady Jr.  
 Jones, Steve A.  
 Jucas, Diana T.  
 King, Billy D.  
 Klein, Kendel L.  
 Landers, Gardner H.  
 Menendez, Moises A.  
 Murfee, Robert M.  
 Payson, Tony A.  
 Pesnell, Larkus H.  
 Pillsbury, Richard C.  
 Pinkerton, Raymond E.  
 Pirnique, Allan S.  
 Ratcliff, John  
 Rogers, Henry B.  
 Sample, Dorothy C.  
 Sarnicki, Joseph  
 Scurlock, William R.  
 Seale, James E. Jr.  
 Smith, George W.  
 Stevens, Willis M. Jr.  
 Talley, H. Aubry  
 Thibault, Frank G. Sr.  
 Tommey, C. E.  
 Tommey, Robert C.  
 Turnbow, R. L.  
 Ulmer, Minna Irene  
 Vasan, Srinii  
 Warren, George W.  
 Weedman, James B.  
 Williamson, John R.  
 Wilson, Larkin M. Jr.  
 Wise, Jean F.  
 Yocum, David M. Jr.  
 Zahniser, Donna J.

### Van Buren County

Hall, John A.  
 Pearce, Charles G.  
 Stuteville, Orion H.

### Washington County

Abernathy, Bryan  
 Albright, Spencer III  
 Applegate, C. Stanley Jr.  
 Arnold, James  
 Atwood, H. Daniel  
 Baggett, Jeff J.  
 Bailey, Scott  
 Baker, C. Murl Jr.  
 Baker, Donald B.  
 Baker, James  
 Beckman, James Jr.  
 Benson, Stuart  
 Bond, Walter M.  
 Bonner, Mark  
 Box, Ivan H.  
 Boyce, John M.  
 Brackin, Jack H.  
 Bredfeldt, Raymond  
 Brooks, W. Ely  
 Brown, Craig  
 Brown, David L.  
 Burnside, Wade W. Jr.  
 Butler, G. Harrison  
 Carver, Joel D.  
 Chase, Patrick R.  
 Cherry, James F.  
 Coker, Tom

Cole, George R. Jr.  
 Cook, Joel P.  
 Cooper, Craig  
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## Advertisers Index

Advertising Agencies in italics

American Physicians Insurance Exchange ....	inside front
Arkansas Express Claims .....	349
Arkansas Blue Cross & Blue Shield .....	343
Arkansas Medical Society .....	309
Arkansas Medical Society .....	356
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
ClaimNet, Inc. ....	347
Collom & Carney Clinic Association .....	355
CompuMedics, Inc. ....	362
Eli Lilly & Company .....	313
<i>Garrison, Jasper, Rose &amp; Company</i>	
Tommy Farrell Associates .....	362
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	375
Freemyer Billing Services .....	309
I CARE of Arkansas .....	back cover
Mediquik Walk-In Clinics .....	347
MEDX .....	375
Orthopaedic Research & Education Foundation .....	345
Radiology Consultants .....	314
Rather, Beyer & Harper .....	353
State Volunteer Mutual Insurance Company .....	310
<i>The Maryland Group</i>	
U.S. Air Force .....	361
<i>Bozell, Inc.</i>	

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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

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**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

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**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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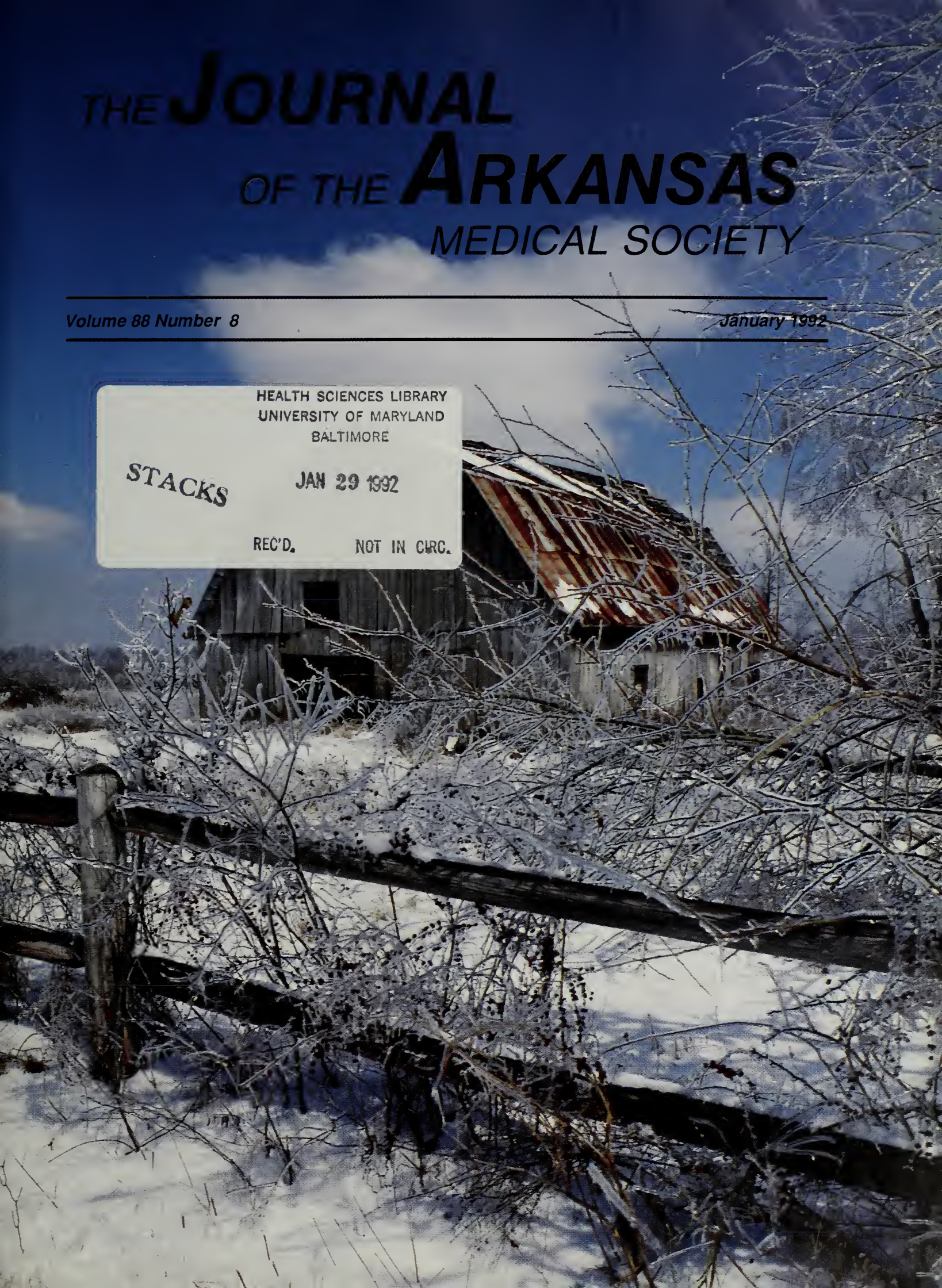
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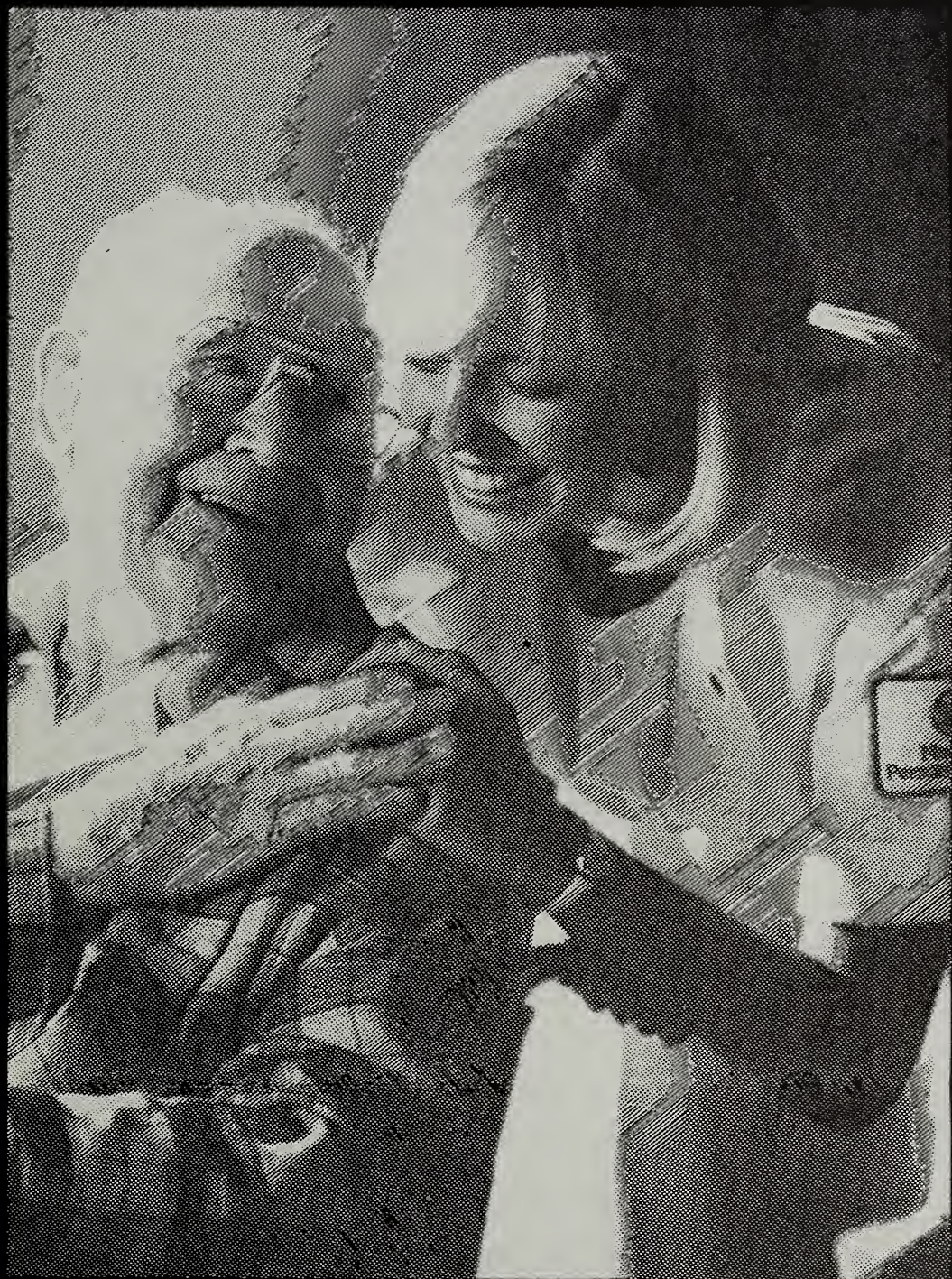
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# Newborn Screening for Hemoglobinopathies in Arkansas: First Two Years' Experience

Robert West, M.D.\*

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**M**ass screening of populations at high risk for sickle cell disease or trait has long been advocated as a public health measure. In the past, such screening often involved initial use of a "sickle cell prep" or solubility test to detect the presence of sickle hemoglobin qualitatively, followed by hemoglobin electrophoresis for positives to distinguish disease states from trait. In children less than six months of age, however, marked inaccuracies in sickle prep and solubility tests from high fetal hemoglobin levels never allowed routine screening in this manner. Furthermore, the previous lack of effective treatment regimens for infants with disease served as a disincentive to early identification through newborn screening.

Screening of newborns for sickle cell disease through hemoglobin electrophoresis was first determined to be accurate and cost-efficient during the 1970's, at which time several states and academic institutions initiated hemoglobinopathy screening projects.<sup>14</sup> The most recent impetus for such screening, however, derives from an NIH-sponsored multi-center study on the effects of prophylactic antibiotic therapy, the results of which were published in 1986.<sup>5</sup> This study demonstrated that prophylactic oral penicillin administered to infants and young children with sickle cell disease significantly reduced the risk of mortality and morbidity due to serious bacterial infections, in particular those caused by *Streptococcus pneumoniae*. The study found that

septic events related to splenic dysfunction began occurring in affected infants as early as four months of age. However, since disease symptoms of pain and anemia usually do not become clinically evident until at least nine to 12 months of age, it was concluded that identification of affected infants through newborn screening would be necessary to allow for optimal initiation of prophylactic antibiotics.

Based upon an estimated incidence of one in 600 in the black population, it can be projected that approximately 14 infants with homozygous sickle cell (SS) disease will be born in Arkansas each year. However, during a two year period prior to 1988, only six infants less than six months old were enrolled in the Comprehensive Sickle Cell Clinic at Arkansas Children's Hospital. Following a mandate by the 1987 General Assembly, Arkansas began screening newborns for sickle cell disease in October, 1988. At the outset, screening was confined to non-white infants only, but beginning in January, 1989, it was expanded to include all newborns. For the period October 1, 1988, through September 30, 1990, the program was substantially funded through a federal Maternal and Child Health Special Projects of Regional and National Significance (SPRANS) grant. This paper summarizes outcomes of screening during this two year grant period.

## Materials and Methods

Hemoglobinopathy screening was incorporated into the existing Newborn Screening Program conducted through the Arkansas Department of Health (ADH), which also coordinates testing and follow-up of newborns for phenylketonuria and congenital hypothyroidism. Heelstick blood specimens were obtained on standard filter paper collection forms from all new-

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borns prior to discharge from the hospital nursery. All testing for hemoglobinopathies was performed at the ADH Public Health Laboratories. During the first year of the grant period, the screening procedure consisted of hemoglobin electrophoresis on cellulose acetate at alkaline pH, followed by secondary citrate agar electrophoresis at acidic pH for specimens having any pattern other than "FA" (fetal hemoglobin present in greater amounts than hemoglobin A). In the second year, a change was made to isoelectric focusing (IEF) as the initial screening assay, with citrate agar electrophoresis used for confirmation of abnormal results. Isoelectric focusing was chosen due to its reported superior resolution of newborn hemoglobins compared to traditional electrophoretic methods.

**Table 1. Interpretation of screening results.**

FA	Presumed normal
FS	Presumed sickle cell disease
FSC	Presumed sickle hemoglobin C disease
FC	Presumed hemoglobin C disease
FE	Presumed hemoglobin E disease
F + Other	Presumed unidentified hemoglobinopathy
FAS	Presumed sickle cell trait
FAC	Presumed hemoglobin C trait
FAD	Presumed hemoglobin D trait
FAE	Presumed hemoglobin E trait
FA + Bart's	Presumed alpha-thalassemia trait
FA + Other	Presumed trait for unidentified hemoglobin
F only	Inconclusive
AF	Possible transfusion

Primary physicians were notified by telephone and letter of screening results suggestive of significant hemoglobinopathies (e.g. FS, FSC, FC). Repeat testing by hemoglobin electrophoresis was requested in these cases, and at the same time pertinent literature regarding recommendations for penicillin prophylaxis was provided to the physician. Recommendations were also made for referral to a comprehensive sickle cell clinic or other pediatric hematologist. Periodic follow-up with the primary physicians was made over several months' time in order to assess results of confirmatory testing and overall disposition of the infants. For screening results indicative of trait states (e.g. FAS, FAC, FAE), both the primary physicians and the parent of the infant were notified in writing. Families of the infants with traits were offered genetic counseling by trained social workers. Such counseling was provided through in-home visits to interested families under a contract with the Sickle Cell Anemia Foundation of Arkansas.

## Results

A total of 68,108 newborn sickle screening results were reported between October 1, 1988, and September 30, 1990. The estimated number of births by occurrence in Arkansas during the period (non-whites only October 1, 1988, through December 31, 1988, plus all for the rest of the period) was 64,234. The excess number of screens is accounted for primarily because hemoglobinopathy screening was routinely performed on all newborn specimens received, including those representing repeats on infants whose first specimens were obtained prior to 24 hours of age or were unsatisfactory. Since by internal audit approximately 5% of initial specimens are obtained prior to 24 hours of age, and just under 1% of initial specimens are unsatisfactory, the inference is that virtually every targeting newborn was screened during the grant period.

Reporting of hemoglobin results followed the standard convention of listing the hemoglobin present in greatest quantity first, followed by the hemoglobins listed in descending order of magnitude. In newborns, fetal (F) hemoglobin is expected to be present in greatest quantity in most cases, unless the infant has been transfused. Table 1 depicts the most common screening results and their interpretation.

As shown in Table 2, a total of 46 presumptive significant hemoglobinopathies were identified during the first two years of screening: 26 FS, 13 FSC, 5 FC, 1 FE, and 1 F + other. Of these 39 (85%) have had repeat (confirmatory) testing, in most cases through a laboratory other than the ADH Public Health Laboratories. Of this latter group, 37 (95%) were found to have a significant hemoglobinopathy, indicating a high predictive value of a positive screening result. The other two infants were found to have simple traits. A breakdown of the 37 confirmed disease states identified is as follows:

Sickle (presumed SS) disease	21
Sickle - Hgb C (SC) disease	10
Sickle - thalassemia	2
Hemoglobin C disease	4

Of the 33 infants confirmed to have a sickling disorder (SS, SC, S-thal), 28 (85%) are known to be receiving comprehensive care including prophylactic penicillin. Of the five who are not, three are still followed by their primary physician, one moved out of state with no forwarding address, and one has not returned to the primary physician since early infancy and could not be located. The three physicians still following the infants with confirmed disease states are believe to have received ample literature regarding the benefits of prophylactic penicillin.

Seven of the original 46 infants with presumed hemoglobinopathies have not yet had confirmatory



testing. Of these, one (FS) reportedly died of intentionally inflicted injuries in very early infancy, three (1 FS, 1 FC, 1 FE) moved and remain lost to follow-up, and three (all FSC) are followed by their primary physician. Delays in obtaining confirmatory testing of presumptive positives proved to be one of the most difficult problems for program staff throughout the two years of the grant. Physician reluctance to pursue repeat testing until the infant reached four to six months of age caused difficulties with some infants who failed to return to that physician for primary care, in addition to delaying the initiation of referral and penicillin therapy.

Three cases of significant hemoglobinopathies are known to have been missed by newborn screening during the grant period: one sickle cell disease, one sickle-hemoglobin C disease, and one hemoglobin C disease. All of these were missed during the first four months of sickle screening, with the errors largely attributable to inexperience of lab personnel with the procedure at the time. All three cases were later picked up through screening in local public health units. No cases are yet known to have been missed in the second year, when isoelectric focusing was employed as the primary screening method. Thus, sensitivity of the screening process apparently improved to the desired 100% level during the second year. One additional infant who initially had an "F only" (inconclusive) result was later identified as having sickle-hemoglobin C disease. All four of these infants are now receiving comprehensive care through the Sickle Cell Clinic at Arkansas Children's Hospital.

Reduction of mortality and morbidity in the affected infants identified is difficult to evaluate at present in view of the relatively small sample size, absence of long-term follow-up, and lack of a control group. Nonetheless, it can at least be stated that review of vital Records revealed no known instances of black infants 0-2 years old with a diagnosis of sickle cell disease who died of sepsis during the grant period. Likewise, the Hematology staff at Arkansas Children's Hospital is unaware of any sickle patients identified through newborn screening who either died of or were admitted with frank sepsis. Only one infant with sickle disease de-

tected through the program is known to have been admitted to ACH with a serious infection, a 13-month old with blood culture-positive pneumococcal pneumonia. This contrasts with the pre-grant situation in which on average one to two infants with sickle cell disease died at ACH each year from overwhelming infections, and many more were admitted. A longer period of follow-up will likely confirm these early observations of improved outcome for young sickle disease patients in Arkansas as a result of early identification and treatment.

As shown in Table 2, sickle cell trait was detected in approximately 6.7% of all black infants screened during the two years. However, this percentage increased

**Table 2. Abnormal Screening Results  
October 1, 1988 - September 30, 1990**

Result	Black No. of Births 16623		White No. of Births 46823		Other No. of Births 631	
	No.	Rate (%)	No.	Rate (%)	No.	Rate (%)
FS	26	0.16	0	0.00	0	0.00
FSC	13	0.08	0	0.00	0	0.00
FC	5	0.03	0	0.00	0	0.00
FE	0	0.00	0	0.00	1	0.16
F + Other	1	0.01	0	0.00	0	0.00
FAS	1121	6.74	60	0.13	26	4.12
FAC	313	1.88	12	0.03	7	1.11
FAD	3	0.02	15	0.03	0	0.00
FAE	1	0.01	1	0.002	15	2.38
FA + Bart's*	137	—	10	—	3	—
FA + Other	139	0.84	53	0.11	7	1.11

\* Identified during the last seven months of the grant period only.

from 5.7% in the first year of the project to 8.0% in the second, substantiating the much improved hemoglobin resolution obtained with the IEF method. Based upon standard estimates of trait prevalence among the black population of approximately one in 12, the latter figure also suggests that at least 80-90% of sickle traits were detected through newborn screening during the second year.

An additional benefit derived through the change to isoelectric focusing was the ability to definitively identify other less common hemoglobin variants, including E, D, G, and Bart's. Bart's hemoglobin, a gamma chain tetramer, is indicative of either alpha thalassemia trait (two gene deletion) or silent carrier state (one gene deletion) when present in small amounts at birth. Since Bart's is present only in early infancy in



affected individuals, newborn screening affords a unique opportunity to definitively identify alpha thalassemia trait. Such identification is important since many infants with the trait will eventually develop a mild microcytic hypochromic anemia, which is often unnecessarily and repeatedly treated with supplemental iron throughout life.

## Discussion

Experience with newborn sickle cell screening in Arkansas suggests that it is not only feasible but also quite effective in identifying infants with significant hemoglobinopathies and assuring them entry into early comprehensive care. Problems encountered to date are similar to those described by screening programs in other states, namely difficulties in tracking infants with presumptive disease states as well as slow physician acceptance of both the accuracy of newborn screening and the benefits of prophylactic penicillin. While some problems involving follow-up are inherent to any mass screening effort, physician acceptance of the program has gradually improved during the two years and should eventually parallel that seen with PKU and CH screening.

### Benefits of Newborn Sickle Cell Screening

- \* Identifies infants at risk for sepsis so that penicillin prophylaxis can be initiated by four months of age.
- \* Allows early referral to comprehensive sickle cell program if desired.
- \* Allows early parent education and genetic counseling.

Children less than six years old with sickle cell disease are particularly susceptible to life-threatening bacterial infections, with *Streptococcus pneumoniae* the predominant causative organism in this age group.<sup>6</sup> Prior to routine use of prophylactic antibiotics, the individual risk for these infections in young Ss patients was about 15%, with case fatality ratios as high as 35%.<sup>7</sup> Penicillin prophylaxis is currently recommended for infants having newborn screening patterns of FS, and (in most sickle cell centers) for those having FSC patterns as well. While the recommendation at present is to continue prophylaxis until the age of five years, further studies are being conducted to determine the true optimal duration of antibiotic therapy. Mean-

while, there is no disagreement that antibiotics should be initiated by no later than four months of age, since the frequency of septic events begins to increase markedly after this point.<sup>5</sup> Given the remarkably high specificity of newborn sickle screening in Arkansas so far, together with the relative safety of penicillin therapy, it seems prudent to recommend that newborns with FS or FSC results on initial screening be started promptly on antibiotics and/or referred to a comprehensive sickle cell center. Penicillin can always be discontinued at a later date in the unusual event that definitive testing reveals the presence of trait rather than disease.

The unnecessary anxiety created in families of the rare false-positives does not appear to outweigh the benefits of early comprehensive treatment for true cases. Early referral also provides for earlier genetic counseling for high-risk families, which optimally should occur prior to conception of additional siblings.

Infants with presumed hemoglobin C disease and hemoglobin E disease have also been identified through newborn screening. Whereas both disorders are associated with moderately severe anemia and persistent splenomegaly, the decision on whether to refer these infants to a pediatric hematologist is best determined by the primary physician and family.

Experience to date suggests that the vast majority of infants with sickle trait and hemoglobin C trait are detectable through newborn screening. Use of isoelectric focusing as the primary screening methodology in the second year appears to be responsible for improved sensitivity in detecting these traits and has also allowed positive identification of other less common hemoglobin variants. Detection of traits in the newborn period permits genetic counseling for new parents, which in turn can lead to early identification of couples at high risk for disease states in future offspring, i.e. parents who both carry the trait.

Finally, the necessity of screening every newborn for hemoglobinopathies could be questioned in view of the lack of disease states as well as the insignificant number of traits detected among white infants. Other states, including those with a relatively low proportion of black births, have investigated this issue, and concluded that universal screening remains cost-effective and desirable.<sup>8</sup> Restricting screening to non-white newborns only would in all likelihood not reduce the cost of the program substantially since many of the laboratory and follow-up costs are fixed regardless of specimen volume. Additionally, such selective screening would introduce an unacceptable risk of missing diseased infants through potential errors at two points: mislabeling specimen collection forms, and mistakes in the complex sorting process that would be required in the laboratory. A 1987 consensus development panel sponsored by the National Institutes of Health and the Health Resources and Services Administration strongly



recommended universal newborn screening for hemoglobinopathies.<sup>9</sup>

In summary, currently available methods of screening newborns for sickle cell disease and other hemoglobinopathies have proven to be sufficiently sensitive and specific to justify their use in mass screening efforts. The observed benefits from early detection and entry into comprehensive health care for affected infants warrant continued hemoglobinopathy screening of all newborns.

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# Combined Raz Urethral Suspension and McGuire Pubovaginal Sling For Treatment of Complicated Stress Urinary Incontinence

Pat D. O'Donnell, M.D.\*

*Urinary incontinence is a debilitating problem that affects over 20 million people in the United States. Anatomical stress incontinence in women has an excellent continence outcome following urethral suspension procedures. However, intrinsic urethral incontinence has a high failure rate following urethral suspension procedures and is usually managed with a pubovaginal sling procedure. Eight patients with both anatomical and intrinsic urethral incontinence were managed with a combined urethral suspension procedure and pubovaginal sling procedure. Seven patients remain continent while one continues to have intrinsic urethral incontinence. The combined urethral suspension procedure and pubovaginal sling procedure appears to provide a treatment option for patients with coexisting anatomical and intrinsic urethral incontinence.*

Urinary incontinence is a problem that causes immense personal distress for millions of people who suffer from the disorder. At least twenty million people in the United States suffer from urinary incontinence.<sup>1</sup> The surgical treatment of stress urinary incontinence in women has an excellent outcome in most cases with approximately 90% of patients being cured of incontinence following a urethral suspension procedure.<sup>2</sup> However, the success of surgery for stress incontinence is much lower in older women or women who have failed previous surgical procedures.<sup>3</sup> These patients not only have anatomical urethral incontinence but also often have associated intrinsic urethral incontinence.

The success of a urethral suspension procedure for anatomical urethral incontinence appears to be dependent upon a high retropubic fixation of the bladder neck as well as repositioning of the bladder neck to a non-dependent position relative to the bladder.<sup>4</sup> Stress incontinence in women due to anatomical prolapse of the bladder neck during episodes of straining responds well to surgical correction of the anatomical abnormality.

However, patients who have intrinsic urethral incontinence have a high failure rate following conventional urethral suspension procedures. A very important clinical categorization of patients with stress urinary incontinence has been the one introduced by McGuire.<sup>5</sup> Along with the definition of Type I and Type II incontinence was the introduction of the concept of the Type III incontinence category which defines intrinsic urethral incontinence. The Type III category represents a group of patients with sphincter dysfunction characterized by a low urethral closure pressure of less than 20 cm H<sub>2</sub>O with or without urethral hypermobility. The value of the clinical identification of this group of women is the extremely high failure rate of conventional urethral suspension procedures for correction of incontinence.<sup>6</sup> Failure of multiple previous operations is associated with a 75% incidence of Type III incontinence.<sup>7</sup>

In the evaluation of the anatomical position of the urethra using a lateral cystogram in the Type III incontinence patient, the urethra and bladder neck are often fixed in a dependent position relative to the bladder. Therefore, it is not possible to position the bladder neck in a high retropubic position without mobilization of the urethra and bladder neck which is best done transvaginally. However, intrinsic urethral incontinence cannot be corrected with a urethral suspension procedure alone and requires a pubovaginal sling to provide

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\* Dr. O'Donnell is a professor with the Department of Urology at the University of Arkansas for Medical Sciences at Little Rock.



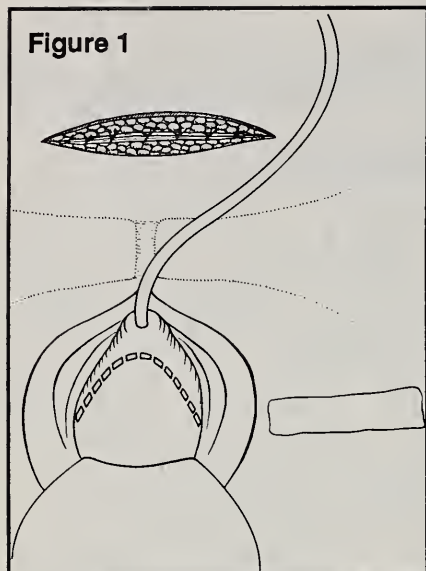


Figure 1

coaptation of the urethral mucosa in order to restore continence.<sup>8</sup> In this difficult management group, an intrinsic urethral dysfunction exists as well as an anatomical urethral abnormality. In these patients, the bladder neck needs to be repositioned and the intrinsic urethral dysfunction needs to be corrected. A Raz

transvaginal urethral mobilization and suspension procedure was combined with a McGuire pubovaginal sling procedure to surgically correct coexisting anatomical and intrinsic urethral incontinence in these patients.

## Methods

Of patients presenting with stress urinary incontinence following failed previous operative procedures, complete radiographic and urodynamic evaluations were performed on all patients and eight patients were identified who had a fixed urethra and bladder neck following previous surgery as well as a maximum closing urethral pressure of less than 20 cm H<sub>2</sub>O consistent with the McGuire Type III intrinsic urethral incontinence. A Raz urethral suspension procedure<sup>9</sup> with mobilization of the urethra and bladder neck was performed in combination with a McGuire fascial sling procedure in each patient.

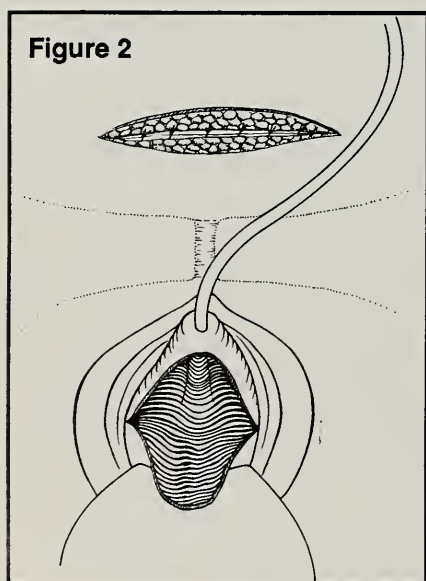


Figure 2

The surgical procedure consisted of removal of a strip of fascia from the anterior rectus sheath. The fascial strip measured three centimeters in width and six centimeters in length. The fascial defect in the anterior rectus sheath was closed with interrupted zero proline sutures. An inverted U-incision was made in the

anterior vaginal wall (Fig. 1). A vaginal flap was mobilized leaving as much of the vaginal wall attached to the urethra as possible to provide a cushion for the fascial sling (Fig. 2). The anterior vaginal wall and endopelvic fascia were separated from the lateral pelvic attachments (Fig. 3). A suture of #1 proline was placed at the bladder neck in a spiral manner through the endopelvic fascia and anterior vaginal wall. The spiral suspension suture was placed on each side of the bladder neck according to the technique described by Raz,<sup>9</sup> (Fig. 4).

The fascial sling was prepared by folding 0.5 cm of each end to make a double layer and a #1 proline suture was placed in a spiral across the sling on each end. It is important that the suture is well secured in the sling to avoid the suture pulling through the sling. A Stamey ligature carrier was used to transfer the Raz urethral suspension sutures to the suprapubic position. These sutures were anchored into the rectus fascia near the

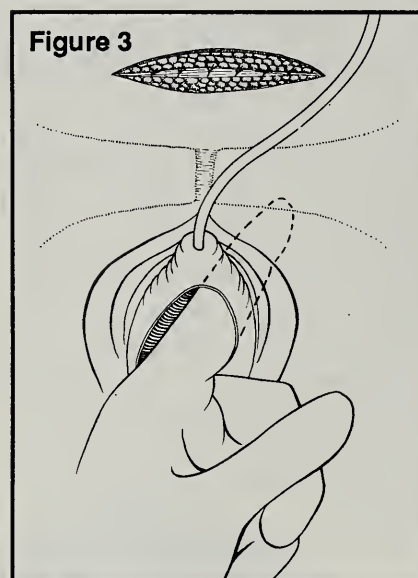


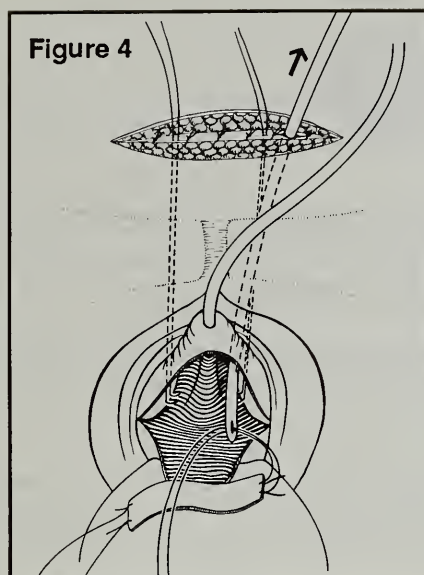
Figure 3

pubis according to the technique described by Leach.<sup>10</sup> The fascial sling sutures were transferred to the suprapubic position medial to the Raz suspension sutures (Fig. 5). The fascial sling sutures also were anchored to the fascia near the pubis (Fig. 6). It is important that the sling remain properly positioned beneath the urethra while the sutures are tied.

The amount of tension placed on the sling is controversial, but most urologists feel that a small amount of tension is adequate. In the cases described in this study, the tension placed on the sling was considerably more than that described by others who use the fascial sling technique. Since erosion of the fascial sling into the urethra is a potential problem, a urethral catheter should not be used in these patients in whom significant tension is placed on the fascial sling.

The vaginal mucosa overlying the sling can be difficult to close once the sling has been secured in position. However, it is better to close the vaginal mucosa after the sling has been positioned in order to be certain that the proper position of the sling has been maintained. A Stamey suprapubic catheter was placed in all of these patients. A vaginal pack was left for 24 hours and a small hemovac was placed in the suprapubic incision for 48 hours.





## Results

Of the eight patients who underwent this operative procedure, seven had urinary retention postoperatively requiring intermittent catheterization for up to four months in one patient, but all subsequently regained spontaneous voiding. All patients were evaluated preoperatively and post-

operatively with resting and straining lateral cystograms. The postoperative lateral cystogram showed high retropubic fixation of the bladder neck in all patients. While the follow up on these patients has been less than one year, seven of the eight patients are completely continent and no longer require intermittent self catheterization.

The patient who failed was restudied both urodynamically and radiographically. The urethra and bladder neck were repositioned anatomically in a high retropubic position and fixed in that position. The stress urethral pressure profile showed loss of pressure transmission throughout the functional urethra and the urethral closure pressure remained low which is consistent with persistent stress urinary incontinence due to intrinsic urethral incontinence.

## Discussion

Intrinsic urethral incontinence or the McGuire Type

III incontinence is usually seen in patients who have failed previous surgery. However, it can be seen in patients with stress urinary incontinence who have not had previous operative procedures. It is unclear whether the failed previous operative procedures contribute to the occurrence of intrinsic ure-

thral incontinence or failure of the operative procedures occurs in patients with intrinsic urethral incontinence selected by failed operative procedures.

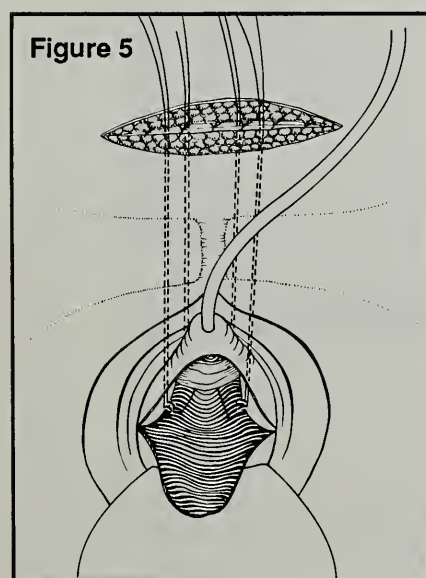
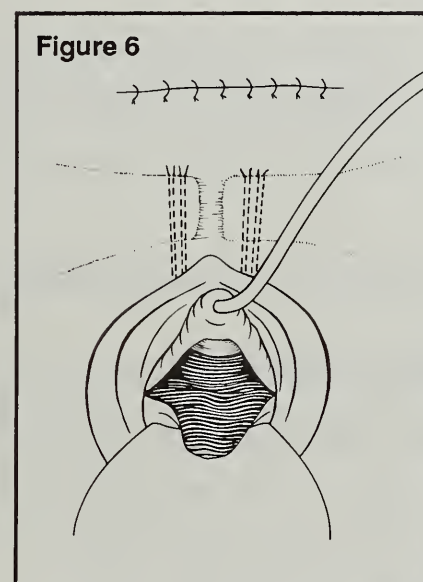
Patients who have intrinsic urethral incontinence are an extremely difficult group to manage surgically. The only operative procedure that has provided success in this group of patients has been the pubovaginal sling procedure.<sup>8</sup> However, in patients who have a fixed urethra due to previous surgical repairs, mobilization and reposition of the urethra is a major consideration for anatomical repositioning of the bladder neck. Historically, repositioning of the bladder neck to a high retropubic position has been an important part of the anatomical correction of stress urinary incontinence. The combination of the concepts of anatomical repositioning of the bladder neck to correct anatomical urethral incontinence and a pubovaginal sling for management of intrinsic urethral incontinence represents

an approach to this complex disorder that addresses both the anatomical urethral abnormality and the intrinsic urethral abnormality that frequently coexist in the patient who has failed previous operative procedures.

## Conclusion

Stress urinary incontinence in women who have

failed multiple previous operative procedures is often due to intrinsic urethral incontinence with associated fixation of the anatomical position of the urethra and bladder neck due to previous operative procedures. A combined Raz urethral suspension procedure and McGuire pubovaginal sling procedure was performed in this group of patients. The combined procedure provide a management approach for both the anatomical urethral incontinence and the intrinsic urethral incontinence. The results of this study suggests that the continence outcome in this extremely difficult group of patients is very favorable using the combined surgical approach. However, a larger series is needed with longer follow up to further evaluate the role of the combined approach as described in this study for the long term management of coexisting anatomical and intrinsic urethral incontinence.





## Addendum

The patient described in the results section as having failed the operative procedure recently wrote, "I am so happy to tell you that after this long period of time, I am finally able to control my bladder." Continence returned in this patient at approximately 11 months following the operative procedure. The mechanism of continence recovery in this case is unclear and repeat urodynamic studies for evaluation of the physiology of continence have not been performed.

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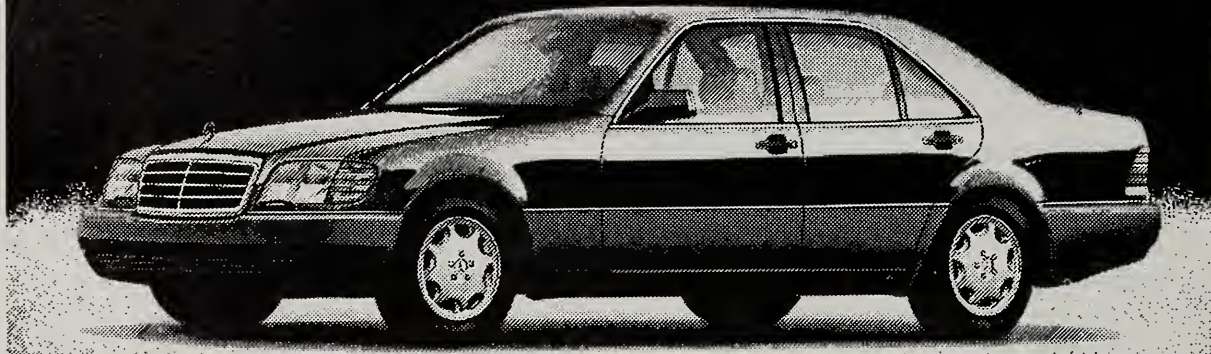
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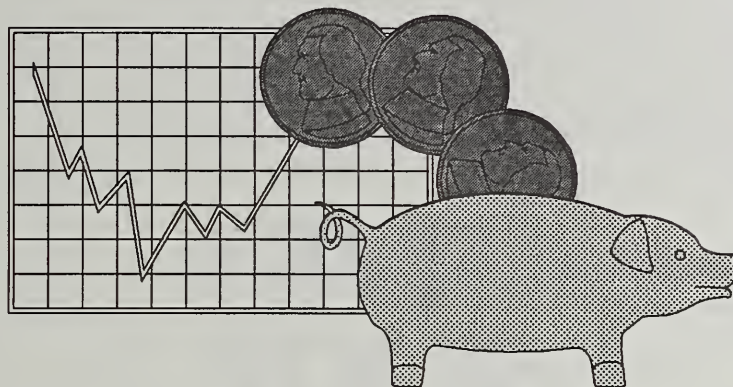
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The development of an investment strategy for the individual investor is a necessity in today's global economy. The strategy should consist of a basic "game plan" and a methodical style of investing.

## The "Game Plan"

Developing a game plan consists of two basic steps:

1. *Analyzing your short, intermediate, and long-term goals.* You may be concerned with a need for a steady retirement income stream, but you may also wish to build up a fund for your children's higher education. By deciding on your goals, you have achieved a tracking system that can be measured for per-

formance on a systematic basis. You will now know how far you have come and how much further you have to go.

2. *Deciding on the amount of risk you are willing to take to achieve your goals.* Risk can be defined in many ways; however, loss of your principle investment would have to be the most severe. This can happen by not out-pacing the rate of inflation (which will create a loss of buying power), and through poor performance of your investments. Through a systematic investment plan, risk can be monitored and controlled.

## The Investment Strategy

The concept of developing a methodical investment strategy is one incorporated by many investors. It allows you to examine investment products and choose those that meet the criteria you have established. When designing this strategy, a portfolio can be divided into three areas:

1. Growth
2. Safety
3. Short-term Needs

Figure 1 illustrates the need for safety of principle and the need for growth in preserving your buying power. How much money goes into each of these areas depends on what you have established as your goals and your tolerance for volatility. Lets look at each area individually.

### Safety

Safety is usually achieved by investing in bonds, CDs, or other fixed income securities. These invest-

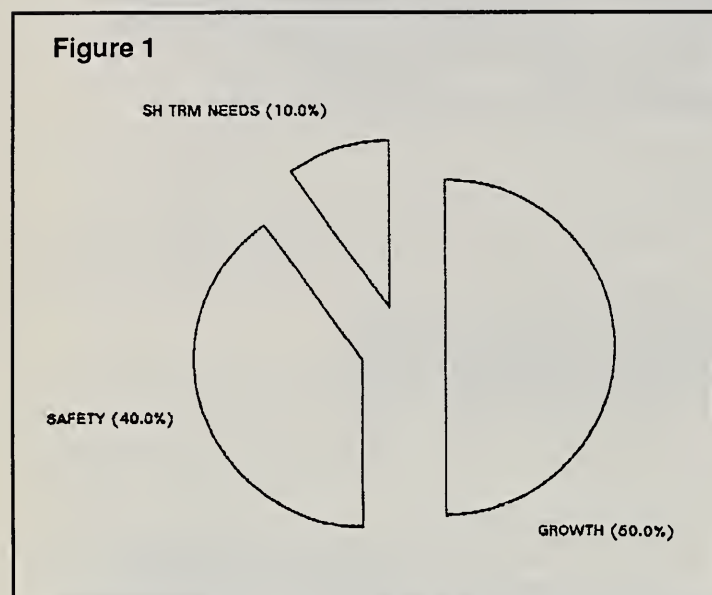
\* Mr. Smith is a financial consultant with Merrill Lynch in Little Rock, Arkansas.



ments will pay you a stated interest rate and give you your principle back at maturity. A common mistake made by investors is either investing all of this in long-term securities (to receive a higher yield) or in short maturities (because of fear of rising interest rates).

In order to hedge against fluctuating interest rates, you need to develop a strategy of staggering your maturities in yearly increments. This will allow you to receive a higher rate of interest than short-term rates allow. It also keeps money coming due on a systematic basis that can be reinvested at current rates.

**Figure 1**



### *Growth*

Growth is usually achieved in a portfolio through the use of stocks or mutual funds. It is important that every portfolio have a percentage of stocks within the investment mix.

The choice of stocks that you use, depends upon your needs and tolerance for risk. For example, utility stocks usually have less price volatility but pay income on a regular basis. Growth stocks are subject to greater volatility but also provide a chance for growth.

When investing in stocks, develop a criteria that each company must meet. This can be done in various ways. The following is one example of analysis:

1. Different industries perform well in the different stages of an economic cycle. Choose an industry that you feel will benefit from future occurrences in the economy.
2. Choose those companies that should prosper within the industries you have selected. This can be accomplished through research reports published by brokerage firms and also through annual reports published by the company.

3. Invest in those stocks which meet the criteria you have designated.

It is important to diversify your investments in different stocks and also in different industries. This can help to lessen the risk usually associated with equities. This can also be accomplished by finding a mutual fund that meets the objectives you are trying to accomplish.

### *Short-term Needs*

Short-term needs are best described as those needs that will arise within the next 12 months. These assets should be held in a money market account or investing in short-term CDs.

Successful investing requires a systematic and long-term approach. A minimum of three to five years should be allowed to receive the full benefit of an investment strategy. During your time horizon, examine your investments and to find out which ones are meeting your objectives and replace the ones that are not.

*This is the first in a series of articles that will discuss the various steps for investing in the 90's. This article was reprinted with permission from Arkansas Business.*

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## ***AIR FORCE RESERVE***



## Asthma increases its number of victims in the United States-- And some of them are physicians sued for malpractice

Robert J. Miller\*

**T**hey *ought* to be rarities. Diseases such as measles, polio, tuberculosis, and asthma have killed millions of people throughout history. But, with improved inoculations for measles and polio, with increased sanitation and medications to fight tuberculosis, and with the variety of drugs and treatments available to battle asthma, these diseases should be disappearing. Instead, each of them is on the increase, not only in the United States but in most other developed nations.

Perhaps the most mystifying upswing is in the number of asthma diagnoses. Asthma is a disease the medical community had hoped to vanquish by the end of the century. But the enemy seems to have reinforcements. Currently, 10 million Americans suffer from asthma.

From the mid-1960s until the late 1970s asthma mortality declined in the United States. But during the decade of the 1980s, deaths resulting from asthma increased by over thirty percent. Debate over the causes of this increase suggest numerous culprits:

### 1. Is our environment causing respiratory problems?

Some health specialists concur with this theory. One recent study cited exceedingly high mortality rates in densely populated inner-cities. Examples included New York City and the Cook County area of Chicago. These same specialists also claim that blacks are 1.8 times more likely to be hospitalized with asthma than whites.

Are blacks more likely to suffer from asthma because they more frequently live in urban environments or is there some other underlying cause? Researchers continue to look for the answer.

It is also interesting to note that asthma rates are climbing, though not as quickly, in rural areas as well. Are there chemicals in the ground water in rural areas, perhaps residue from pesticides and fertilizers, that could be contributory?

There may be yet another environmental key: the ozone layer. The US Public Health Service (USPHC) has posited that air pollution and ozone may be related to increased morbidity and mortality among American asthma victims. The USPHC has set a target reduction of asthma hospitalizations to fewer than 160 per 100,000--this goal to be reached by the year 2000.

### 2. Are patients less compliant?

The "old-fashioned" approach to asthma treatment assumed that children grew out of it. In many instances, they don't, but as they achieve some level of autonomy in their own health care, perhaps they are less likely to follow the regimens that have been established. Although mortality levels increased most in youngsters age five to 15, there has also been a noticeable jump in the number of attacks among young adults, 16 to 25.

If they are feeling well, do young people stop taking medication, stop using their inhalers and nebulizers? When they begin to experience symptoms, are they more likely to delay taking medication because of excessive confidence in the drugs and inhalers? Are they slower to report to their physicians or to hospitals when they experience difficulty breathing under the mis-

---

\* Mr. Miller is vice president of Consumer Affairs and Risk Management for The Medical Protective Company of Fort Wayne, Indiana.



taken belief that inhalers/medication *always* work? Other research proposes that antiasthma drugs allow patients to endure greater exposure to antigens and other asthma-provoking agents with the greater likelihood of longer-lasting and more severe reactions.

3. Are physicians less likely to take asthma attacks seriously?

In several malpractice suits filed against physicians insured by The Medical Protective Company, patients admitted to the hospital with severe asthmatic attacks did not always receive aggressive attention. Following is a commentary presented by an expert witness hired by the defense to evaluate the quality of care given to a patient who died as a result of her asthma:

"...the physicians did not appreciate the severity of [Mrs. X's] asthma. When she presented to the Emergency Room there was a history of difficulty breathing at home, mouth-to-mouth resuscitation, and wheezing. If a physician is treating a known asthmatic, then the patient should be put on heavy dosage of steroids..."

"There are occasions when asthmatics will die and the physician cannot do anything about it. However, if a physician suspects a severe asthmatic problem in a known asthmatic, there are certain things that should be done. First, the patient should be put on steroid prophylactically."

"[Here there follows some commentary about the patient's maintenance dose being insufficient and a questioning of the defendant doctor's decision to leave the dosage at a maintenance level. This patient's Proventil inhaler was also taken away from her, another cause of criticism of those treating her, another potential negative factor.] Secondly, Dr. Y should have done a peak flow test with a spirometer device [to test lung function]."

The patient in this case had been a 47-year-old, married female RN with one child still living at home. She had had a history of asthmatic problems and had been admitted to the hospital for previous breathing problems.

In the admission that eventually lead to her death, the treating physician's search for another cause of cyanosis rather than the most obvious cause--the asthma--may have contributed unfavorably. Continued expert witness evaluation of care cited:

"The autopsy showed bilateral pneumothorax. This could have been caused by the resuscitation or it could have been caused by the asthma. A bad asthmatic attack can cause both lungs to collapse and it is true that the patient may die before any-

thing can be done. It is more likely that the collapsed lungs were probably caused by the asthmatic attack. In [the expert's] opinion the autopsy showed bloody-mucus linings and this is certainly consistent with an asthmatic attack. The attack should never have occurred if she had been on [high dosage] steroids."

In another suit filed against an emergency room physician, the allegations of negligence accused the ER of failing to note the patient's previous hospital admissions for asthmatic attacks and for failing to evaluate her dangerously abnormal Theophylline levels.

In yet another case, a family physician who had treated an asthmatic patient for a number of years was taken to task in the courtroom for poor records and for failure to perform regular testing in order to evaluate the patient's long-term progress:

"...recordkeeping of a substandard level. It [the record] reflects no thought process and [I] was forced to read between the lines to see what their thinking was during the course of treatment."

"...further agreed that there should have been a yearly pulmonary function test to determine baseline readings."

The upshot of these suits is that physicians need to take asthmatics seriously. Treating physicians should maintain records that reflect a PLAN for maintenance and care. Close communication between the patient's personal physician and specialists is essential and regular test results, changes in medication, as well as any attacks should be provided for both offices.

Parents must be encouraged to stay involved in the maintenance plans for teenage asthmatics. While young people want to establish some independence, this may be an area in which parents should still provide some monitoring. Adolescent noncompliance is a documented factor in some asthmatic deaths. One research project warns of patients with potentially fatal asthma (PFA) who exhibit antisocial personality disorders and who may require a combination of medical and psychiatric care.

As the number of deaths from asthma rise, so does the number of malpractice suits filed against treating physicians. It is certainly possible that asthma sufferers and their families may have unnaturally high expectations for their treatment. But physicians, through education of patients (and their families), through design and adherence to a regular and competent health plan, through aggressive treatment of asthma attacks, and through accurate and complete records, should be able to provide the best possible care for their patients--and should also be able to protect themselves from unnecessary suits.



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**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

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Additional information available to the profession on request.



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# Constitution and Bylaws of the Arkansas Medical Society

## CONSTITUTION

### ARTICLE I. Name of Society

The name of this organization shall be the Arkansas Medical Society.

### ARTICLE II. Purposes of the Society

The purposes of this Society shall be:

1. To federate and bring into one compact organization the entire medical profession of the State of Arkansas and to unite with similar societies of other states to form the American Medical Association;
2. To extend medical knowledge and advance medical science;
3. To elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws;
4. To promote friendly intercourse among physicians;
5. To guard and foster the material interests of its members and to protect them against imposition;
6. To enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life; and
7. To maintain medical ethics and to secure compliance with the art and science of medical practice.

### ARTICLE III. Component Societies

Component societies shall consist of those societies which hold charters from this Society as provided in the Bylaws.

### ARTICLE IV. Members

The Arkansas Medical Society is composed of individual members of its component societies and others as may be provided for in the Bylaws.

### ARTICLE V. Sections and District Societies

The House of Delegates may provide for a division of the work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of this Society.

### ARTICLE VI. House of Delegates

The House of Delegates shall be the legislative and policy-making body of the Society composed of members elected by the component societies and others as provided in the Bylaws. The House of Delegates shall transact all business of the Society not otherwise provided for in this Constitution and Bylaws and shall elect the general officers except as may be provided in the Bylaws.

### ARTICLE VII. General Officers

The officers of this Society shall be a president, president-elect, vice president, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, a secretary, a treasurer, an immediate past president, and councilors. Their qualifications and terms of office shall be as provided in the Bylaws.

### ARTICLE VIII. Council

#### Section 1. Duties

The Council shall be the executive body of the House of Delegates and between sessions of the House shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall constitute the Finance Committee of the House of Delegates.

#### Section 2. Composition

The Council shall consist of the councilors, the president, vice president, president-elect, secretary, treasurer, immediate past president, and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates, and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote.

#### Section 3. Executive Committee

The Chairman of the Council, the president, the



president-elect, the secretary, the treasurer, and the immediate past president shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have such powers and duties as provided in the Bylaws and as may be defined from time to time by resolution of the Council.

#### **ARTICLE IX. Sessions and Meetings**

The Society shall hold a meeting of the House of Delegates at least annually and at other times as deemed necessary or as provided in the Bylaws. The place and time for holding each meeting shall be determined by the Council.

#### **ARTICLE X. Funds, Dues and Assessments**

Funds may be raised by annual dues, or assessments, on the members of the Society except as provided in the Bylaws. The amount of dues or assessments shall be fixed by the House of Delegates on four-fifths vote of the delegates present, provided that a written notice has been sent to all dues paying members at least 90 days prior to the House of Delegates meeting. Funds may also be raised from voluntary contributions, society publications and services. All resolutions appropriating funds must be referred to the Council before action is taken thereon.

#### **ARTICLE XI. Referendum**

The House of Delegates may, by a two-thirds vote, order a general referendum on any question pending before it, and when so ordered the House of Delegates shall submit such questions to the members of the Society, who may vote by mail or in person. If the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding upon the House of Delegates.

#### **ARTICLE XII. The Seal**

The Society shall have a common seal, with power to break, change or renew the same at pleasure, by action of the House of Delegates.

#### **ARTICLE XIII. Amendments**

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.

## **BYLAWS**

### **CHAPTER I. Membership**

#### **Section 1. General Requirements**

A person seeking application to this Society must fulfill at least one of the following requirements:

(A) Possess the degree of Doctor of Medicine or Osteopathy AND hold a license to practice medicine and surgery issued by the Arkansas State Medical Board; (B) Serve as an Intern/Resident in an approved training program in this state; or (C) Be enrolled as a Medical Student in an approved medical school in this state.

Any person when becoming a member shall agree to abide by the Constitution and Bylaws of this Society and by any changes which from time-to-time may be made. The member further agrees to abide by the Principles of Medical Ethics of the American Medical Association.

#### **Section 2. Membership Categories**

Categories of membership are: A. Active; B. Active Direct; C. Life; D. Emeritus; E. Affiliate; F. Associate.

##### **(A) Active**

Active members are members of component societies who are entitled to exercise the rights of membership in their component society. A person eligible for Active membership shall become a member of this Society upon certification by the secretary of the component society to the Arkansas Medical Society Executive Vice President that the person meets the requirements for membership in Chapter I, Section 1, of these Bylaws. Intern/residents and medical students shall be entitled to the same rights and privileges accorded other members except that they shall not hold office or chair committees.

##### **(B) Active Direct**

Active Direct members are those who apply for membership in this Society directly rather than through a component society. Intern/residents and medical students shall not be eligible for this category.

(1) Active Direct members are admitted to membership upon application to the Executive Vice President and after approval by the Executive Committee of the Arkansas Medical Society. When reviewing applicants for Direct membership, the Executive Committee shall establish that the applicant meets the requirements of membership as outlined in Chapter I, Section 1, of these Bylaws and may



consider information pertaining to the character and ethics of the applicant. The Committee shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

- (2) The Arkansas Medical Society shall immediately notify the secretary of each component society of the name and address of those applicants for Active Direct membership residing within its jurisdiction.
- (3) Objections to applicants for Active Direct membership must be received by the Executive Vice President within 30 days of receipt by the component society of the notification of application. Any objections will be referred to the Executive Committee of the Arkansas Medical Society for disposition.
- (4) Active Direct members shall have the right to vote, hold office, and all other privileges of membership in this Society.

(C) Life

A physician who has been an Active or Active Direct member of this Society for a period of ten years and who has continuously been a member of organized medicine and has either (1) attained age seventy or (2) practiced forty-five years shall be eligible for life membership. Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society. Life members shall have the right to vote, hold office, and all other privileges of membership in this Society.

(D) Emeritus

A physician who has been an Active or Active Direct member of this Society for a period of ten years and who has continuously been a member of organized medicine for less than forty-five years and who has fully retired from the practice of medicine shall be eligible for emeritus membership. Such status shall be granted by the House of Delegates upon the recommendation of the members' component society or, in the case of an Active Direct member, the Executive Committee of the Arkansas Medical Society. Emeritus members shall be entitled to all privileges of this Society except that they shall not hold office.

(E) Affiliate

An Active or Active Direct member in good

standing may be granted affiliate membership where one or more of the following conditions exists: physical or other disability of a character preventing the practice of medicine, a serious and prolonged illness, financial reverses, or service in the armed forces of the United States, not as a career officer. Affiliate membership shall be on an annual basis only and must be recommended each year for such special status by the member's component society or, if an Active Direct member, the Arkansas Medical Society Executive Committee following a review and reassessment of the particular situation. Affiliate members shall enjoy full membership privileges except that they shall not have the right to vote or hold office.

(F) Associate

Physicians who are licensed to practice medicine and surgery in this State as well as an adjacent state and are engaged in the delivery of health services in both states may become associate members of this Society provided they are active members of the state medical association in the adjoining state. Associate members may vote as provided in this Constitution and Bylaws and may serve on all committees, but shall not hold office.

Section 3. Dues Exemption

- (A) Life, emeritus, affiliate, intern/resident, and student members shall be exempt from the payment of dues and assessments.
- (B) Associate members shall pay one-half of all dues and assessments.
- (C) New active members of the Society entering practice in Arkansas shall be exempt from dues from the date of entry into practice until the next regular dues period. The following year, the dues assessment shall be at one-half the total amount. Thereafter, full dues are payable.
- (D) The House of Delegates upon recommendation from the Council, may assess a nominal annual fee on Life and Emeritus members to cover administrative and overhead costs associated with providing Society publications and services.

Section 4. Delinquency

Members are considered delinquent if their dues and assessments are not received by this Society by March 1, of each year, or by such other date as may be prescribed by the House of Delegates. Delinquent members shall not be entitled to any rights or benefits of this Society, nor shall they take part in any of its proceedings until such delinquency has been resolved.



## Section 5. Suspension or Termination of Membership

- (A) Any member shall have their membership suspended or terminated for failure to pay their annual dues and assessments or upon official notification from a component society that a member is not in good standing, subject to the member's right of appeal as provided in Section 6 of this Chapter.
- (B) The Executive Committee, after due notice and hearing, may suspend or terminate a person's membership in the Arkansas Medical Society for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct, subject to the member's right of appeal as provided in Section 6 of this Chapter.
- (C) Membership in the Arkansas Medical Society shall automatically be terminated if a member ceases to meet the requirements for membership as specified in Section 1 of this Chapter. This provision shall not apply to Life or Emeritus members who have fully retired from the practice of medicine.

## Section 6. Appeals

- (A) Any member who may feel aggrieved by the action of this Society or of the member's component society in denying membership, or in suspension or termination, shall have the right to appeal to the Council.
- (B) Notice of Appeal shall be filed with the Council within thirty (30) days of the date of the action on which the appeal is taken, and the appeal shall be perfected within ninety (90) days thereof. The decision of the Council shall be final.
- (C) The Council Chairman shall have the power to appoint special committees from among the members of the Council to hear appeals; provided no member from the same councilor district as the appellant shall serve on said committee.
- (D) The Council shall establish rules and procedures to be followed in hearing appeals and shall furnish these to all parties involved in the appeal upon receipt of the Notice of Appeal.

## CHAPTER II. Component Societies

### Section 1. Charters for Component Societies

- (A) All component societies now in affiliation with this Society or those which may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and Bylaws,

shall, on application and submission of their Constitution and Bylaws, receive a charter from and become a component part of this Society.

- (B) As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.
- (C) Charters shall be issued only on approval of the Council, and shall be signed by the President and Secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

### Section 2. Component Organization

Only one component medical society shall be chartered in any county, except in the county where the University of Arkansas College of Medicine is located. In that county there may be, in addition to the regular county medical society, one component society for interns and residents and one component society for medical students. Where more than one component society exists in any other county, friendly overtures and concessions shall be made, with the aid of the councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

### Section 3. Membership Qualifications

Each component society shall judge the qualifications of its own members, but as such societies are chartered components of the Arkansas Medical Society, every person who possesses the qualifications for membership required by Chapter I, Section 1 of these Bylaws shall be eligible for membership.

### Section 4. Transfers

Members in good standing in a component society who move to another county in this State shall be given a written certificate of these facts by the secretary of the component society, without cost, for transmission to the secretary of the society in the county to which they move. Pending their acceptance or rejection by the society in the county to which they move, such member shall be considered to be in good standing in the county society from which they were certified and in the Arkansas Medical Society to the end of the period for which their dues have been paid.

### Section 5. County Jurisdiction

Physicians living near a county line may hold their membership in that county society most convenient for them to attend, on permission of the com-



ponent society in whose jurisdiction they reside.

#### Section 6. Efforts to Increase Membership

Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

#### Section 7. Representation in the House of Delegates

At some meeting in advance of the Annual Session of this Society, each component society shall elect a delegate or delegates to represent it in the House of Delegates as provided in Chapter IV, Section 7 of these Bylaws and the secretary of the component society shall send a list of such delegates to the Executive Vice President of this Society at least ten days before the Annual Session.

#### Section 8. Responsibilities of secretary

The secretary of each component society shall endeavor to keep a roster of its members, and of the non-affiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state and such other information as may be deemed necessary. In keeping such roster, the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making the annual report shall endeavor to account for every physician who has lived in the county during the year.

#### Section 9. Annual Report

The secretary of each component society shall forward its Annual Report to the offices of this Society no later than March 1 of each year. Such report shall include but not be limited to:

- A. Names of officers and their terms
- B. Names of delegates
- C. Names of physicians who have been dropped from membership
- D. Names of deceased physicians
- E. Names of members requesting change in membership category
- F. Any dues and assessments collected by the component society in behalf of the Arkansas Medical Society and/or American Medical Association. Such monies shall be accompanied by a listing of the name, address, and amount remitted for each member.

#### Section 10. Failure to Submit Annual Report

Any component society which fails to remit any dues and assessments collected in behalf of the Arkansas Medical Society and/or American Medical Association or who fails to submit the Annual

Report, as defined in Chapter II, Section 9, on or before March 1 of each year, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of this Society or of the House of Delegates until such requirements have been met.

### CHAPTER III. Annual And Special Sessions Of The Society

#### Section 1.

The Society shall hold an Annual Session of the House of Delegates at such place as has been fixed by the Council.

#### Section 2.

Special meetings of the House of Delegates shall be called by the President on petition of the Council, twenty delegates, or fifty members.

### CHAPTER IV. House Of Delegates

#### Section 1.

The House of Delegates shall meet on the first day of the Annual Session. It may recess from time to time as may be necessary to complete its business; provided that its hours shall not conflict with the general meetings.

#### Section 2.

The order of business shall be arranged as a separate section of the Annual Session program.

#### Section 3.

The House of Delegates shall establish its own rules of procedure.

#### Section 4. Items of Business

- (A) All reports and resolutions received by the Executive Vice President sixty days prior to the annual meeting of the House of Delegates of this Society shall be printed in the Journal of the Arkansas Medical Society in the month preceding the meeting.
- (B) All reports, resolutions, and other items of business received by the Executive Vice President twenty days prior to a meeting of the House of Delegates shall be included in the meeting agenda.
- (C) Any item of business not submitted to the Executive Vice President twenty days prior to the meeting of the House of Delegates must have a two-thirds consent of attending delegates for introduction at such session.

#### Section 5. Reference Committees

- (A) The Speaker of the House of Delegates shall appoint an appropriate number of reference committees from the membership. The Chairman shall be appointed by the Speaker. The reference committees shall serve only during the convention for which they are appointed.



- (B) All reports of committees, reports of officers, and resolutions submitted for consideration of the House of Delegates shall be referred to a reference committee, unless otherwise provided in these Bylaws, or unless otherwise ordered by a two-thirds vote of the House of Delegates.
- (C) The reference committee shall hold an open hearing at which any member of the Society may speak on proposals before the committee.
- (D) The reference committee shall recommend to the House of Delegates an appropriate course of action on each proposal referred to the committee.

#### Section 6. Composition

The House of Delegates shall consist of:

- (A) Delegates elected by component societies in accordance with Section 7 of this chapter, or as provided in Section 10 of this chapter.
- (B) The Councilors
- (C) The president, vice president, president-elect, speaker, vice speaker, secretary, treasurer, and past presidents of the Society.

#### Section 7. Representation of Component Societies

Representation for the House of Delegates shall be based upon the number of active, active direct, life, emeritus, and associate members as of December 31 of the year preceding the annual meeting. Medical student and intern/resident members shall not be included in the enumeration of active and active direct members for purposes of representation.

- (A) Each regular county society shall be entitled to send to the House of Delegates each year one delegate for every twenty-five Arkansas Medical Society members, as specified in this section, and one for each major fraction thereof, provided that its annual report is in the hands of the Executive Vice President by March 1st of each year. Each county society, which has complied with this section, shall be entitled to at least one delegate.
- (B) The component society composed of intern/resident members shall be entitled to one delegate to the House of Delegates.
- (C) The component society composed of medical student members shall be entitled to one delegate to the House of Delegates.

#### Section 8.

A majority of the delegates registered shall constitute a quorum.

#### Section 9. The House of Delegates shall:

- (A) elect representatives to the House of Delegates of the American Medical Association in accordance with the constitution and bylaws of that body,

- (B) divide the State into councilor districts, specifying what counties each district shall include and, when the best interest of the Society and profession will be promoted thereby, organize in each a district medical society, and all members of the Arkansas Medical Society shall be members in such district society,
- (C) have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports,
- (D) approve all memorials and resolutions issued in the name of the Society before they shall become effective, and
- (E) it shall transact all business of this Society not otherwise provided for herein.

#### Section 10.

In case of vacancy in the office of delegate, the House of Delegates shall have the authority to seat any member of that county society in attendance at said meeting as delegate, with full right to perform all the duties of that office.

### CHAPTER V. Election of Officers

#### Section 1. Nominating Committee

The Nominating Committee shall consist of ten members of the House of Delegates, one from each councilor district. Each member of the committee shall serve for a term of two years, the terms being staggered so that odd and even numbered councilor district representatives shall be replaced on alternate years. The names of the delegates appointed to the nominating committee shall be submitted by the senior councilors in the districts to the Executive Vice President no later than thirty days prior to the annual meeting. Following the first meeting of the House of Delegates at the Annual Session, the Nominating Committee shall meet and organize by selecting a chairman and a secretary. It shall be the duty of this committee to consult with members of the Society and to hold one or more meetings at which time the best interest of the Society and of the profession of the State for the ensuing year shall be carefully considered. The committee shall report the result of its deliberations to the headquarters office no later than February 1 in the shape of a ticket containing the names of one or more members for each of the offices to be filled at the Annual Session.

#### Section 2.

Nothing in this Chapter shall be construed to prevent additional nominations being made by members of the House of Delegates.

#### Section 3.

No member shall be elected to any office of this



Society who is not in attendance at the meeting at which the election is held. Exceptions may be made by the House of Delegates if the nominee is unable to be present because of circumstances beyond his control.

#### Section 4.

The election of officers shall be the first order of business of the House of Delegates on the last day of the Annual Session.

#### Section 5. Election by Ballot

All elections shall be by written ballot, except where there is only one candidate, when election may be made by acclamation, and a majority of the votes cast shall be necessary to elect.

#### Section 6. Terms of Office

(A) Councilors shall be elected to serve a two-year term; provided no councilor shall serve more than four consecutive terms. This limit shall not apply to the councilor who (1) is serving as chairman, and (2) is otherwise eligible to be re-elected chairman; provided no member shall serve as chairman more than six consecutive years.

(B) Delegates and Alternate Delegates to the American Medical Association shall be elected in accordance with the Bylaws of that organization; provided no member shall serve for more than a combined total of 12 consecutive years. This limit shall not apply to any delegate or alternate delegate while serving in an elected or appointed position to an AMA council, committee, or board.

(C) All other terms of office shall be for one year; provided no member shall serve more than six consecutive years in the same office.

(D) Members who have served in an office for the maximum number of years or terms are eligible for re-election to that same office after one year.

(E) All officers shall serve until their successors are installed.

(F) Provisions of this section shall apply to all current officers and fifty percent of their accumulated years in office shall count toward the specified limits.

(G) Once provisions of this section have been implemented, paragraphs (F) and (G) shall be deleted from these bylaws.

#### Section 7.

On the expiration of the term as president-elect, that person shall automatically succeed to the presidency and shall serve as president for the ensuing year.

#### Section 8. Vacancy in Presidency

In the event of the death or removal of the President, the President-elect shall succeed to the

presidency to serve the remainder of that year and the ensuing year.

#### Section 9. Vacancy in Office of President-elect

In the event of the death or removal of the President-elect or the inability to serve, the Vice President shall succeed to the position until the next Annual Session at which time a special election for the office of President shall be held.

#### Section 10. Councilor Vacancy

In the event of the death or resignation of a district councilor, the Council shall appoint a member of the district to fill the unexpired term. The remaining councilors for the district shall confer with members in the district and make nominations for the vacancy to the Council.

#### Section 11. Vacancy in Office of Secretary or Treasurer

In the event of a vacancy in the office of the Secretary or of the Treasurer, the Council shall fill the vacancy until the next annual election.

### CHAPTER VI. Duties of Officers

#### Section 1. President

The President shall preside at all meetings of the Society and shall appoint all committees not otherwise provided for. The President shall deliver an annual address at such time as may be arranged, and shall perform such duties as custom and parliamentary usage may require.

#### Section 2. President-elect

The President-elect shall be a member of the Council and the House of Delegates. It shall be the President-elect's duty to assist the President in visiting the component and district societies, and to become familiar with, and prepare for, the performance of his the duties of the office of President. In the event of the President's temporary inability to serve, the President-elect shall serve until such time as the President is able to return.

#### Section 3. Vice President

The Vice President shall assist the President in the discharge of the President's duties. The Vice President may be assigned by the President as an ex-officio member of certain committees of the Society. The Vice President's responsibilities will be to stimulate, to guide, to maintain liaison, and to otherwise assist the assigned committees and their respective chairmen in the performance of their activities. In no instance will the Vice President usurp or supplant the committee chairmen in their responsibilities. The Vice President shall not have a vote in the affairs of the committees assigned under provisions of this section.

#### Section 4. Treasurer

The Treasurer shall give bond in the sum as directed by the Council, and shall demand and



receive all funds due the Society, together with bequests and donations. The Treasurer shall pay money out of the treasury only on a written order of the Executive Vice President; he and shall subject the Society's accounts to such examinations as the House of Delegates may order. The Treasurer shall annually render an accounting of the state of the Society's funds.

#### Section 5. Secretary

The Secretary, in case of vacancy in the office of the executive vice president, shall assume the duties of that office pending the filling of the vacancy, and shall perform such other duties as are imposed by the Constitution and Bylaws. The Secretary shall be the scientific and professional advisor of the Executive Vice President.

#### Section 6. The Speaker of the House

The Speaker of the House of Delegates shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

#### Section 7. The Vice Speaker

The Vice Speaker shall officiate for the Speaker in the latter's absence or by request. In case of death, resignation, or removal of the Speaker, the Vice Speaker shall officiate during the unexpired term.

#### Section 8. Councilors

Every councilor shall be organizer, peacemaker, and censor for their district. The one in each district with the longest tenure shall be considered the senior councilor. It is recommended that the councilors in each district call a meeting of the members in the district at least once each year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for informing, improving, and increasing the knowledge and zeal of the component societies and their members.

#### Section 9. Chairman of the Council

The Chairman of the Council shall (1) preside at all meetings of the Council, (2) serve as Chairman of the Executive Committee of the Council, and (3) appoint the Council committees.

### CHAPTER VII. Council

#### Section 1. Power and Duties

- (A) The Council shall be the executive body of the House of Delegates and between Annual Sessions exercise the power conferred on the House of Delegates by the Constitution and Bylaws. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Society. All questions of an ethical nature brought before the House of Delegates or the general

meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members on which an appeal is taken. The Council shall elect a chairman following election of the Council members by the House of Delegates.

- (B) The Council shall be responsible for the conduct of all the business affairs of the Society. It shall employ a chief executive officer who shall be known as the Executive Vice President.

- (a) The Executive Vice President shall be responsible for implementation of policies of the Society and conducting affairs of the Society under the direction of the Council and its Executive Committee, the House of Delegates and the President. The Executive Vice President shall be the directing manager of the Society's headquarters office and the Journal office, and shall supervise the work of all salaried employees in the Society's offices. The Executive Vice President shall discharge the administrative functions of the Society not within the duties of other officers or of committees to perform and shall assist, at their request, all officers and committees. The Executive Vice President shall keep informed in regard to nonprofessional matters affecting the medical profession, for the purpose of remaining qualified to perform the services herein mentioned. The amount of salary shall be fixed by the Council and the Executive Vice President shall give bond as directed by the Council.

#### Section 2. Composition

The Council shall consist of the councilors, the president, vice president, president-elect, secretary, treasurer, immediate past president, and the Speaker of the House of Delegates. The Vice Speaker of the House of Delegates and the Delegates and Alternate Delegates to the American Medical Association shall be members ex-officio without vote.

There shall be two councilors from each district which has two hundred members or less. In districts where there are more than two hundred members, there shall be an additional councilor for each additional one hundred members. The councilors shall serve staggered terms of two years each. All councilors shall have equal voting privileges. A majority of the voting members shall constitute a quorum.

#### Section 3. Representation

Representation on the Council shall be based upon the enumeration of members in each councilor



district in accordance with the provision for representation in the House of Delegates as defined in Chapter IV, Section 7 of these Bylaws.

#### Section 4. Organizing Component Societies

The Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

#### Section 5. Publications and Records

The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memories of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. It shall annually audit the accounts of the Treasurer and Secretary and other agents of this Society and present a statement of the same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

#### Section 6. Meetings

The Council shall meet on the first day of the Annual Session and daily during the session and at such other times as necessary, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Society to organize and outline the work for the ensuing year. Between Annual Sessions, the Council shall meet at least quarterly.

#### Section 7. Reporting

The Council shall, through its chairman, make an annual written report to the House of Delegates.

#### Section 8. Bonds

The Council shall have authority to accept or reject all bonds, commitments and contracts.

#### Section 9. Committees

##### (A) Executive Committee

The Chairman of the Council, the President, the President-elect, the Secretary, the Treasurer, and the Immediate Past President shall constitute the Executive Committee of the Council. The Chairman of the Council shall serve as Chairman of the Executive Committee. The Executive Committee shall have the power and authority to act for the Council between meetings of that body; all actions of the Executive Committee shall require approval or ratification of the Council. The

Executive Committee shall consider matters referred to it by officers of the Society and shall report its findings or recommendations to the Council. The Executive Committee shall have jurisdiction in all matters pertaining to (1) Active Direct membership and (2) discipline of members, subject to the member's right of appeal as provided in Chapter 1, Section 6 of these Bylaws.

##### (B) Budget Committee

The Budget Committee shall consist of (a) four members appointed by the Chairman of the Council from among the councilors, and (b) the Arkansas Medical Society treasurer. The four council members shall be appointed to four-year terms, staggered so that one member is replaced each year. The terms shall begin on January 1 and end on December 31 of the appropriate years. The member with the most seniority shall serve as chairman. The Budget Committee shall present to the Council, before the first of each year, an annual budget consisting of anticipated revenue and expenses for the ensuing year as well as a report of the Society's committed and non-committed reserves. Any significant request for funds not included in the annual budget should be reviewed by the Budget Committee before they are committed. The Budget Committee shall provide for an annual independent financial audit and work to maintain the most prudent use of Society assets.

##### (C) Council Committees

The Chairman shall, with concurrence of the Council, appoint such committees as are necessary to carry out the duties assigned to the Council by the Bylaws and House of Delegates.

#### Section 10. Appointments to Fill Vacancies

The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates.

### CHAPTER VIII. Committees

Section 1. Committees may be appointed by the president, chairman of the Council, or as may be so ordered by the House of Delegates to carry out the goals and responsibilities of this Society.

Section 2. Unless otherwise provided, all committees will be of two types: (1) Standing committees with staggered membership terms; and (2) Ad Hoc committees and Task Forces for specific purposes with limited duration.

Section 3. All committees shall have a written



mission-statement that includes to whom the committee reports, the goal or purpose of the committee, and when applicable, the perceived or required time-frame for completion of the committee's work.

Section 4. All committees except those required by the Constitution and Bylaws shall be evaluated periodically, but not less than once every three years, to identify and abolish or restructure committees that are non-functional or whose purpose or mission has significantly changed or ended. It shall be the responsibility of the Executive Committee to conduct such evaluation and make recommendations to the appropriate body.

Section 5. Unless otherwise provided, standing committees shall consist of at least six members with each member appointed to a three-year term; provided no member shall serve more than two consecutive terms.

#### CHAPTER IX. Required Attendance By Elected And Appointed Members

Any member, appointed or elected, to any position within this Society who is absent from three consecutive meetings, or who annually misses fifty percent of the meetings of the body to which they serve, shall be presumed to have resigned that

position, provided, written notification has been given prior to a person missing the critical number of absences.

#### CHAPTER X. Parliamentary Procedures

The deliberations of this Society shall be governed by parliamentary usage as contained in *Sturgis Rules of Parliamentary Procedure*, when not in conflict with this Constitution and Bylaws.

#### CHAPTER XI. Medical Ethics

The Principles of Medical Ethics promulgated by the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

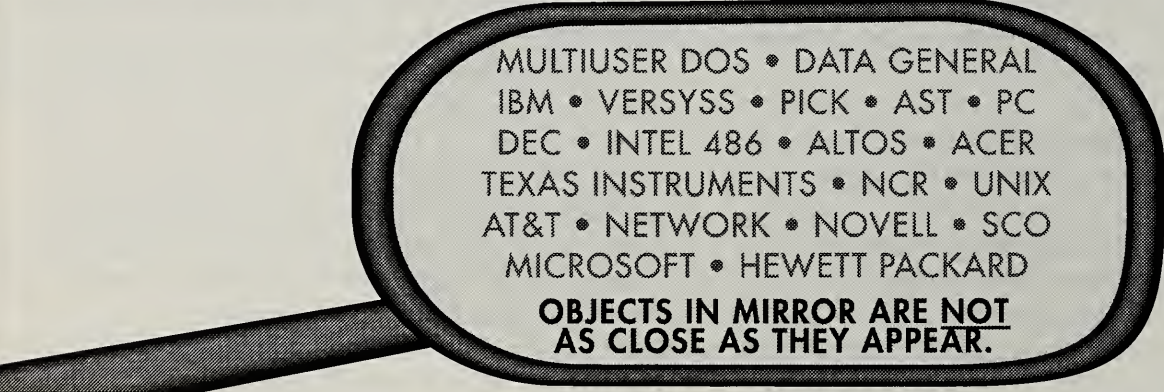
#### CHAPTER XII. Amendments

The House of Delegates may amend any chapter of these Bylaws by a two-thirds vote of the delegates present at any meeting of the House of Delegates, provided that the amendment shall have been mailed to all members at least 90 days prior to the meeting.

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Revised April 27, 1991

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**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

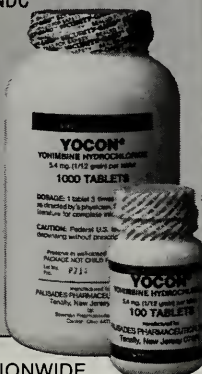
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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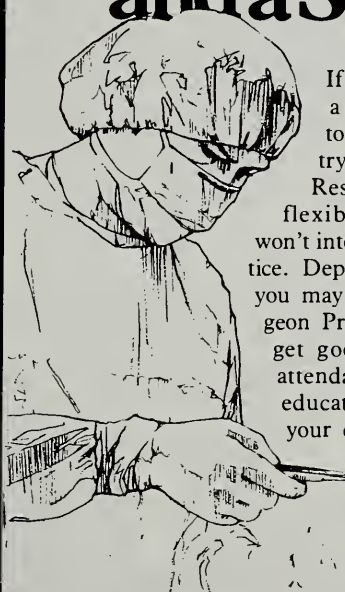
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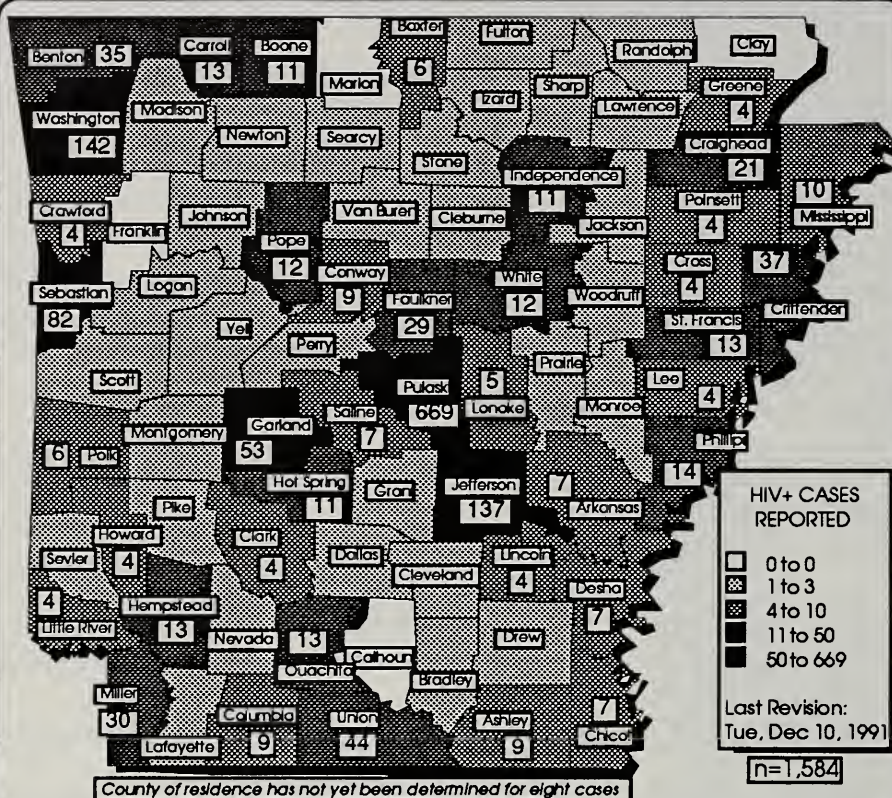
14-214-0005

A GREAT WAY TO SERVE



# Arkansas HIV/AIDS Report

## 1983-1991



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

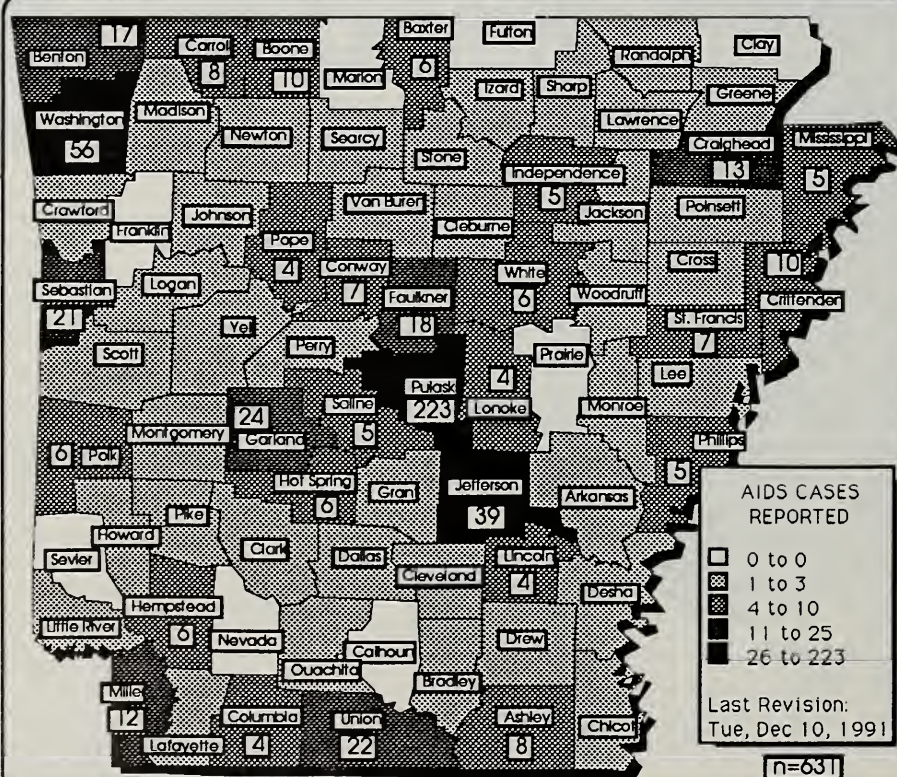
- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.

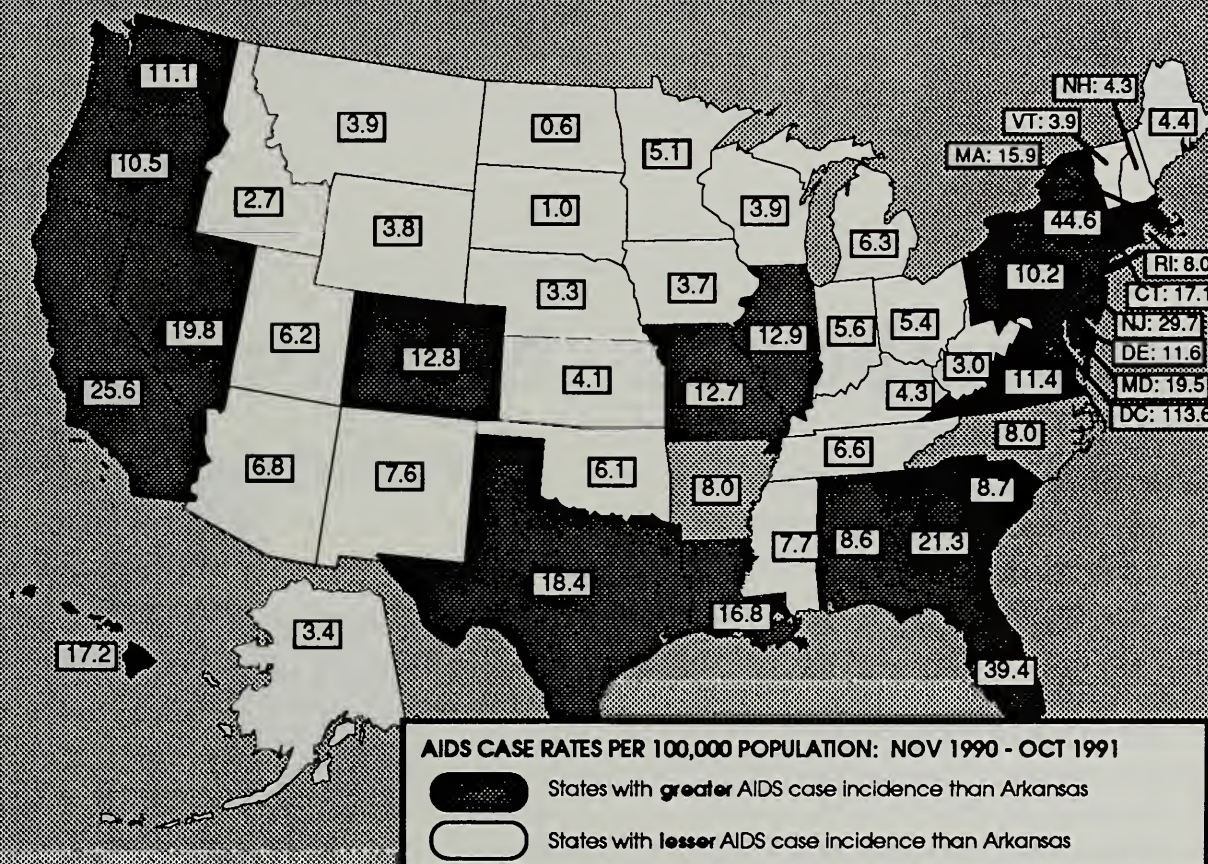




# Arkansas AIDS Report

## 1983-1991

Arkansas Cases		United States Cases	
Reported: NOV '90 - OCT '91	196	Reported: NOV '90 - OCT '91	44,672
Rates per 100,000 population: NOV '90 - OCT '91	8.0	Rates per 100,000 population: NOV '90 - OCT '91	17.5
Cumulative Reports: 1983 - NOV '91	631	Cumulative Reports: 1980 - OCT '91	199,406
Adult	615	Adult	196,034
Pediatric	16	Pediatric	3,372
Deaths: 1983 - NOV '91	348	Deaths: 1980 - OCT '91	126,491
Adult	342	Adult	124,693
Pediatric	6	Pediatric	1,798
Mortality Rate	55.2 %	Mortality Rate	63.4 %



Arkansas Cases by Risk Group		United States Cases by Risk Group	
Men who have sex with men	61.3 %	Men who have sex with men	57.5 %
Heterosexuals who use IV Drugs	11.4 %	Heterosexuals who use IV Drugs	22.0 %
Men who have sex with men and use IV Drugs	9.8 %	Men who have sex with men and use IV Drugs	6.4 %
Heterosexual contact with person at risk	5.2 %	Heterosexual contact with person at risk	5.7 %
Transfusion with blood products	4.8 %	Transfusion with blood products	2.3 %
Infants born to HIV-infected mothers	2.1 %	Infants born to HIV-infected mothers	1.4 %
Persons with hemophilia	1.9 %	Persons with hemophilia	0.9 %
Risk unknown at this time	3.5 %	Risk unknown at this time	3.7 %

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# AMS Newsmakers

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**Dr. James A. Clardy**, of Texarkana, has been appointed medical director at Pinewood Hospital.

**Dr. Jim English**, a Little Rock plastic surgeon, has been elected president of the Arkansas Academy of Otolaryngology, Head and Neck Surgery.

**Dr. G. Thomas Jansen**, a dermatologist from Little Rock, recently received the Southern Medical Association's Distinguished Service Award for 1991 during the President's "Doctors' Day" awards luncheon. The Distinguished Service Award is presented in recognition of outstanding contributions to the advancement of medical science and/or the Association.

**Dr. Patricia Knott**, of Little Rock, has been named associate medical director with Central Arkansas Rehabilitation Hospital in Sherwood.

**Dr. Paul Kramm**, medical director of Central Arkansas Rehabilitation Hospital has been certified as a diplomate of the American Board of Physical Medicine and Rehabilitation, making him eligible to become a full active member and fellow of the American Academy of Physical Medicine and Rehabilitation.

**Dr. Milton Lubin**, a family physician from West Memphis, has been recertified as a diplomate of the American Board of Family Practice (ABFP).

## New Members

### CRAIGHEAD/POINSETT COUNTY

**Suprock, Mark D.**, Orthopedics, Jonesboro. Born, July 3, 1957. Medical education, Hahnemann Medical College, Philadelphia, PA, 1981. Internship/residency, Hamot Medical Center, 1988. Practice experience, 2 years.

### ST. FRANCIS COUNTY

**Meredith Jr., James T.**, General Practice, Forrest City. Born, September 1, 1952, Crossett. Medical education, UAMS, 1980. Internship, AHEC-Pine Bluff, 1981. Practice experience, 10 years.

### MEMBERS-AT-LARGE

#### *Jacksonville*

**Schexnayder, Rebecca E.**, Pediatrics. Born, November 27, 1959, Stuttgart. Medical education, UAMS, 1986. Internship/residency, UAMS, 1989. Board certified. Practice experience, 2 years.

### MEDICAL STUDENTS

**Aidoo, Jennifer-Adwowa A.**  
**Roofe, Scottie B.**

## Medicine in the News

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### Health Care Access Foundation Update

As of December 30, 1991, the Arkansas Health Care Access Foundation has provided free medical services to 3,328 medically indigent persons.

The program has 1,465 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties in Arkansas.

**We're Fighting For Your Life.**



**American Heart  
Association**





# It's Mardi Gras Time!

*Come Experience the  
New Orleans Atmosphere.*

## 1992 Annual Session

Friday, April 10, 1992

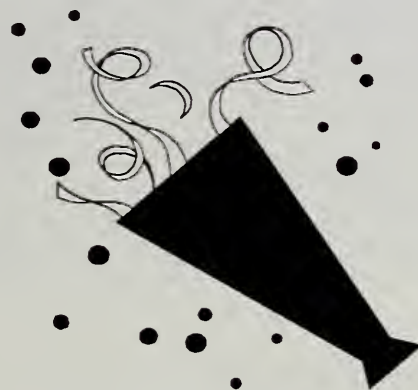
Ballroom/2nd Floor

Excelsior Hotel

Little Rock, Arkansas

7:00 p.m.

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# Resolution

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## L. Gordon Holt, M.D.

Whereas, the members of the Pulaski County Medical Society notes with sincere sorrow the recent death of their esteemed colleague, L. Gordon Holt, M.D.; and

Whereas, Dr. Holt was a highly respected member of this organization for 50 years and had given generously of his time and talent to positions of leadership in the medical community; and

Whereas, his devotion to his patients and his community service as the Pulaski County Coroner will be long remembered; be it therefore

*RESOLVED*, that this resolution be adopted and stored in the permanent archives of the Society; and

*RESOLVED*, that a copy be sent to Dr. Holt's family as an expression of our heart-felt sympathy; and

*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
November 20, 1991

By Order of the Memorials Committee  
Marlon J. Doucet, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

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*Memorials honoring Arkansas Medical Society members and their spouses  
can be made to the Medical Education Foundation for Arkansas (MEFFA),  
P.O. Box 5776, Little Rock, AR 72215-5776.  
Call the Society at (501) 224-8967 or 1-800-542-1058 for more information.*

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# In Memoriam

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## Mrs. Carmen Murphy

Mrs. Carmen Ivy Murphy, of Little Rock, died Wednesday, November 13, 1991. She was 76.

Survivors are her husband, Dr. Randolph Murphy; a daughter, Mrs. W. John Giller Jr. of El Dorado; a sister, Mrs. Fred Holden of Newport; four grandchildren and four great-grandchildren.

## Joe W. Chamberlain, M.D.

Dr. Joe Warren Chamberlain, a retired surgeon from Hot Springs, died Friday, December 6, 1991. He was 58.

Dr. Warren was a member of the American Medical Association, the Arkansas and Garland County Medical Societies.

Survivor is his wife, Mrs. Jeanie Chamberlain.



# Plastic & Reconstructive Surgery . . . The Expanding Horizon

*We restore, replace and make whole those parts which nature hath intended but which fortune hath taken away, not so much to delight the eye of the beholder . . . but to ease the mind of the afflicted.*

- Gaspar Tagliacozzi 1597

The featured quotation is from a treatise on nasal reconstruction written nearly four centuries ago. The psychological impact of deformity was well recognized then as it is today. Persons with congenital or acquired facial deformity have difficulty in today's society. Many times a person who does not fit the norm is considered mentally deficient only on the basis of appearance.

Current state-of-the-art techniques in plastic and reconstructive surgery offer hope for many conditions considered untreatable only several years ago. These new techniques have largely been developed by the subspecialties of craniofacial surgery and reconstructive microsurgery.

Craniofacial surgery deals with comprehensive diagnosis and management of facial deformity and disfigurement. Techniques include moving portions of the facial skeleton such as orbits (eye sockets), jaws, or skull; bone grafting; rigid miniplate fixation; and planning to carry out these alterations in ways to minimize facial scarring. New techniques of 3-D diagnostic imaging play an ever-increasing role.

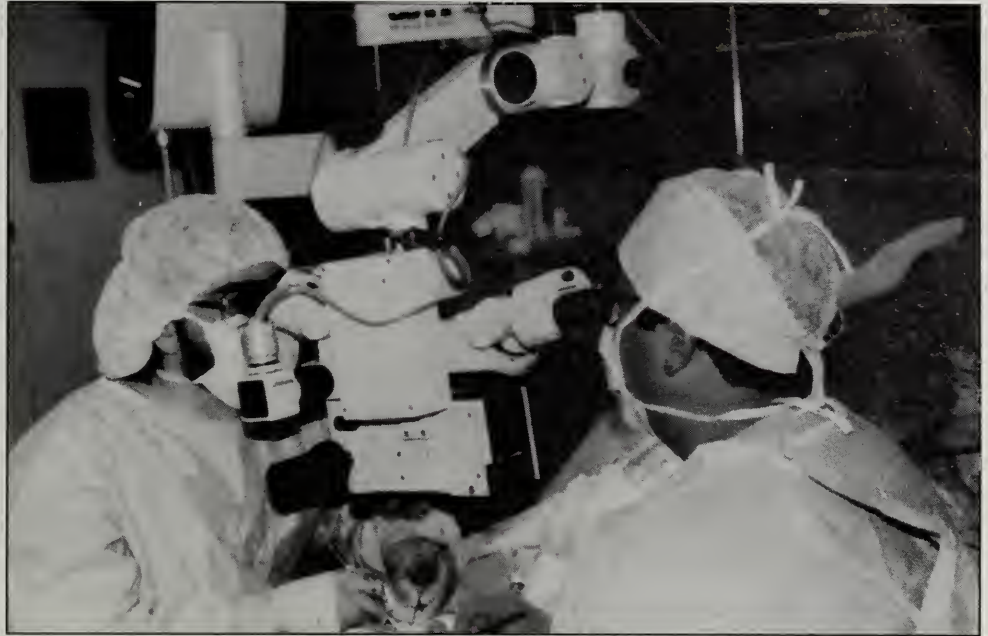
Conditions treated are the relatively common cleft lip and palate deformities; post-traumatic facial deformities; and rare syndromes such as Crouzon's, Apert's, Treacher-Collins, hemifacial microsomia, and craniosynostoses.

Craniofacial surgery requires a multi-disciplinary team approach. This team includes the craniofacial and neuro-surgeons, anesthesiologist, speech pathologist, otolaryngologist, psychologist, pediatrician, and social worker. The goal of this team is the successful outcome of a complex facial reconstruction.

*Plastic surgery is an art form — an exacting discipline whose effectiveness often depends on a harmonious blend of medical science and art. To transfer bulk tissue and maintain its viability is applied science; to shape that tissue into graceful anatomic form is artistry.*

Burt Brent

*The Artistry of Reconstructive Surgery*



*Drs. Franz (left) and Bise shown completing a microsurgery procedure.*

The newest subspecialty in plastic and reconstructive surgery is reconstructive microsurgery. This involves the capability to either reattach severed body parts or to transfer tissue from one part of the body to another by reconnecting arteries and veins to restore the blood supply to the transferred part. An example would be the transfer of a toe to replace a lost thumb or a muscle to cover exposed joints or bone. The vessels are so tiny the reconstruction is done under a microscope with sutures finer than human hair.

Reconstructive microsurgery can be combined with craniofacial surgery to reconstruct many defects previously considered untreatable. These defects can result from trauma, cancer or birth defects.

Thousands of people with essentially normal appearance undergo aesthetic plastic surgery yearly. They do this to improve self-image and to possibly improve or maintain an edge in the competitive field of business.

The Plastic Surgery Center at Holt-Krock Clinic has the capability to carry out these advanced techniques in addition to traditional plastic surgery procedures such as facial aesthetic surgery like facelift or rhinoplasty, burn reconstruction, breast surgery, hand surgery, and cancer surgery. The Center draws on the medical staff resources of Holt-Krock Clinic, the largest private, free-standing clinic in a six-state area.

Doctors F. Perry Franz and Roger N.

Bise have full training in plastic and reconstructive surgery with additional fellowship training from recognized world authorities. Both are candidate members of the American Society of Plastic and Reconstructive Surgeons.

The Plastic Surgery Center  
Institute for Craniofacial Surgery  
Institute for  
Reconstructive Microsurgery

F. Perry Franz, M.D.  
Plastic and Reconstructive Surgery  
Reconstructive Microsurgery

Roger N. Bise, M.D., D.D.S.  
Plastic and Reconstructive Surgery  
Craniofacial Surgery

Doctors Bise and Franz are Board  
Certified by the American Board of  
Plastic Surgery and are members of the  
American Society of Plastic and  
Reconstructive Surgeons.



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# Things To Come

## January 24-25, 1992

**Transfusion Medicine 1992.** Arlington, Virginia and Los Angeles, CA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$190.00, members; \$240.00, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

## March 13-15

**19th Annual Scientific Meeting of the American College of Nuclear Medicine.** Sheraton New Orleans Hotel, LA. For more information, contact Thomas Johnson at (717) 898-6006.

## March 27-28

**Leukocyte Reduction and Blood Component Therapy.** Stouffer Concourse Hotel, Arlington, VA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$200, members; \$250, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

## April 22-26

**Symposium on Management of Common Infections in Practice; 12th Annual National Pediatric Infectious Disease Seminar; and Special Session on Risk Management in the Pediatric Office.** Grand Hyatt Hotel, Washington, D.C. Sponsored by the Department of Pediatrics, Southwestern Medical School, The University of Texas Southwestern Medical Center. Fees: \$350; \$250, residents, fellow, PA's and PNP's. AMA Category I, AAFP, and PREP credits available. For more information, contact Marian Troup at (214) 688-8845.

## April 22-26

**6th Annual Critical Care Update.** Hyatt Regency-Capitol Hill, Washington, D.C. Co-sponsored by the Society of Critical Care Medicine, Rush Presbyterian-St. Luke's Medical Center, in cooperation with the Critical Care Medicine Department of the Clinical Center of the National Institutes of Health. Category I credits available. For more information, contact Svetlana Lisanti at (201) 385-8080.

## April 27- May 1

**25th National Conference on Breast Cancer.** The Westin Hotel, Copley Place, Boston, Massachusetts. Sponsored by the American College of Radiology.

## May 2-4

**18th Annual Meeting of the Federated Ambulatory Surgery Association.** The Boston Marriott, Copley Place, Boston, Massachusetts. For more information, call (703) 836-8808.

## VOLUNTEERS

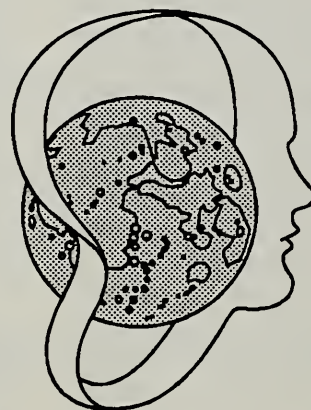


## THE WAVE OF THE '90s

For more information on volunteer management, training, and recognition, call the Arkansas Division of Volunteerism at 1-800-432-5850, ext. 27540.



## The Changing World of Medicine



## Arkansas Medical Society 116th Annual Session

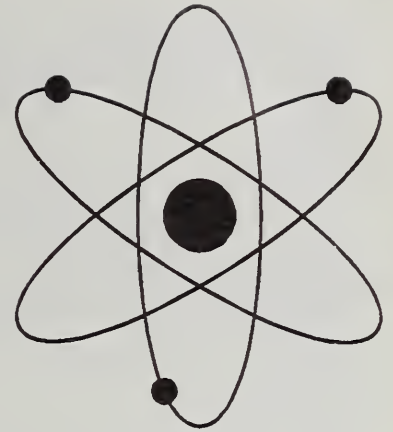
**Excelsior Hotel • Statehouse Convention Center**

**Little Rock, Arkansas**

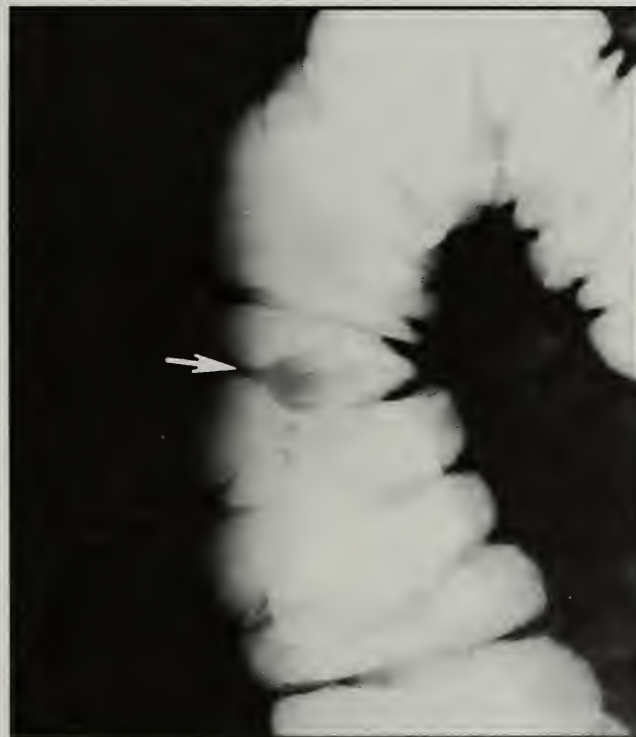
**April 9 - 11, 1992**



# Radiological Case of the Month



Stephen K. Tplick, M.D.  
David L. Harshfield, M.D.  
Steven R. Nokes, M.D.



*Figure 1. Polypoid filling defect in the mid ascending colon (white arrow).*

## History:

A 79-year-old white male presented to the Emergency Room with rectal bleeding. Blood work revealed anemia. History was negative for change in bowel habits or size of caliber of stool.

Physical examination revealed no evidence of hemorrhoids or lesions within the reach of the index finger rectally. Rigid colonoscopy failed to reveal pathology, however, there was evidence of blood in the colon.



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# Pedunculated Polyp

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## Radiographic Findings:

Colonoscopy was not readily available at the presenting hospital, and a barium enema was performed with full column technique.

## Discussion:

The patient was referred for Colonoscopy, which revealed the pedunculated polyp at the site identified by the barium enema. The polyp was removed endoscopically and revealed no evidence of malignant change.

### *Review of Lower G.I. Bleeding*

Although tumors, especially polyps, may bleed, they generally bleed intermittently and cause chronic anemia.<sup>1</sup> Significant acute colonic bleeding is usually secondary to diverticular disease and, less commonly, angiodysplasias.<sup>2</sup> Barium studies and Colonoscopy readily detect colonic neoplasms but often fail to detect the site of an acute bleed. Radionuclide scans are highly sensitive and can provide localization of the site of acute colonic bleeding.<sup>3</sup> Angiography also may be helpful in patients who are actively bleeding and can be used for therapy as well as diagnosis.<sup>4</sup>

Diagnosing the site of colonic bleeding is important because operative morbidity in patients undergoing emergency colectomy without determining the site is 38%, whereas in those patients in whom the bleeding site is located, the morbidity rate is less than 10%.<sup>5</sup>

Although diverticula are more common in the left side of the colon, two thirds of bleeding diverticuli occur from right-sided colonic diverticula.<sup>6</sup> Vasopressin has been shown to control diverticular hemorrhage successfully in 80% to 90% of patients.<sup>7</sup>

Angiodysplasias (vascular ectasias) are generally located in the cecum or ascending colon and, unless large, may not be visualized by endoscopy or barium enema. On angiography they have a characteristic cluster of vessels seen during the arterial phase, may demonstrate intense staining during the capillary phase, and may have early draining veins.<sup>8</sup>

Angiodysplasias may present as chronic anemia with episodes of recurrent GI bleeding or, less commonly, as life-threatening hemorrhage. Of interest is the associated incidence of aortic stenosis in patients with unexplained GI bleeding.<sup>9</sup> As many as one fourth of patients with colonic angiodysplasia have aortic stenosis.<sup>9</sup> It has been hypothesized that these patients have concurrent development of these two diseases related to an underlying endothelial defect.

## References

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8. Wolff WI, Grossman MB, Shinya H. Angioplasty of the colon: diagnosis and treatment. *Gastroenterology*, 1977; 72:329.
9. Boley SJ, Sammartand R, Adams A, et al. On the nature and etiology of vascular ectasis of the colon: degenerative lesions of aging. *Gastroenterology*, 1977; 72:650.

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*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is in private practice and is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Stephen K. Tplick, M.D., is vice chairman, Department of Radiology, University of Arkansas for Medical Sciences in Little Rock.*

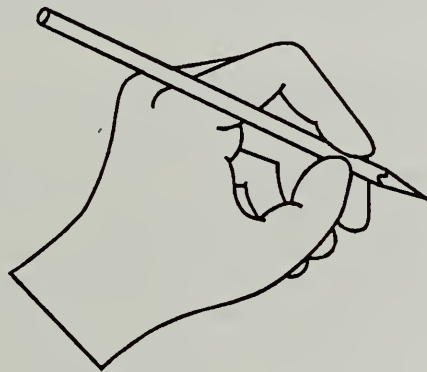


# Topics in Search of Authors

You can influence your peers - and give something back to your profession - if you plan to write an article for *The Journal of the Arkansas Medical Society*.

*The Journal* needs your thoughts and ideas. So why not consider putting your expertise on paper? Here are some of *The Journal's* topics in search of an author.

- Practice management for today's physicians
- Coping with difficult patients
- Women's health issues
- Teens and drug use
- Medicare/Medicaid issues
- Medical ethics and health care
- What's the value of organized medicine?
- New treatments and technology
- Cutting the belt on health-care costs
- Medical history of Arkansas
- A smokeless society
- A doctor's hobby
- Medicine of the future
- Waste management update
- How to market your practice
- Access to care for the indigent
- Erosion of the physicians' image



For more details, call or write:  
Stephanie Percefull  
Managing Editor  
*The Journal of the Arkansas Medical Society*  
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Little Rock, AR 72215  
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# Keeping Up

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## **Annual Cardiovascular Update**

February 28, 1992, J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. For more information, call BMC Medical Affairs at (501) 227-2672.

## **Arkansas Hand Club Annual Meeting**

May 8-9, 1992, Gaston's White River Resort, Lakeview. For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference* (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
*Medical Grand Rounds*, Fridays, 12:00 noon, VAMC

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon*, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar*, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
*Genetics Conference*, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
*Infectious Disease Conference*, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
*Pediatric Grand Rounds*, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
*Pediatric Neuroscience Conference*, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
*Pediatric Pharmacology Conference*, 5th Wednesday, 12:00 noon, 2nd Classroom  
*Pediatric Research Conference*, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
*Journal Club*, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
*Chest Conference*, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
*Joint Tumor Conference*, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
*GYN Surgery Cancer Conference*, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
*Hematology-Oncology Conference*, 2nd Thursday, 12:00 noon, Pathology classroom. Lunch provided  
*Cancer Center Team Conference*, 3rd Thursday, 12:00 noon. Lunch provided  
*Sleep Disorders Case Conference*, every other Thursday, Video Production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., conference room 1  
*GI Conference*, 4th Friday, 12:00 noon, conference room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided. Category 1 credits available.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided



*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06  
Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06  
CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
Cardiothoracic Surgery Conference, date, time, & location varies  
Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
CME Outreach Program, dates, times & locations vary  
Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI auditorium once a month  
LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC  
Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33  
Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C  
Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue  
Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room  
Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D  
Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D



*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## **FORT SMITH - AHEC**

*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th & 5th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center



*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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Advertising Agencies in italics

American Physicians Insurance Exchange ....	inside front
Arkansas Express Claims .....	388
Arkansas Blue Cross & Blue Shield .....	393
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Central Arkansas Rehabilitation Hospital ....	back cover
<i>Fowler Martin &amp; Associates</i>	
ClaimNet, Inc. ....	380
Collom & Carney Clinic Association .....	427
Eli Lilly & Company .....	400/401
<i>Garrison, Jasper, Rose &amp; Company</i>	
Tommy Farrell Associates .....	380/394
<i>Thomas J. Farrell Agency</i>	
Holt-Krock Clinic .....	419
<i>The Williams Agency</i>	
Medical Personnel Pool .....	381
Medical Protective Company .....	402
<i>Ferguson Advertising, Inc.</i>	
MEDX .....	412
Orthopaedic Research & Education Foundation .....	392
Palisades Pharmaceuticals .....	413
<i>Design and Advertising</i>	
Radiology Consultants .....	387
Rather, Beyer & Harper .....	386
Riverside Motors, Inc. ....	394
<i>Benson/Smith Advertising</i>	
State Volunteer Mutual Insurance Company .....	378
<i>The Maryland Group</i>	
Tanyard Springs .....	377
<i>A. Tim Irby Advertising, Inc.</i>	
U.S. Air Force .....	417
<i>Bozell, Inc.</i>	
U.S. Air Force Reserve .....	397/413
<i>Hameroff/Milenthal/Spence, Inc.</i>	

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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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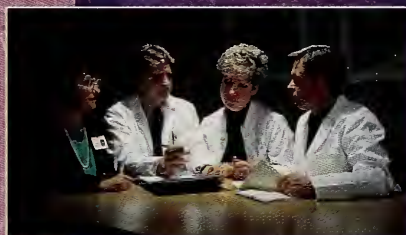
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Volume 88 Number 9

February 1992

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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

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## CONTENTS

### FEATURES

- |     |  |
|-----|--|
| 433 | <b>1991: The Year in Medicine<br/>with Bold Predictions for 1992</b><br><i>Editorial</i><br>Lee Abel, M.D. |
| 437 | <b>Ramipril: A Review of the New ACE Inhibitor</b><br>Tom P. Mills, R.Ph.                                  |
| 443 | <b>RBRVS Medicare Physician Payment Reform<br/>A New Era in Payment Practices</b>                          |
| 446 | <b>The Loser Finally Wins</b><br><i>Loss Prevention Case Study</i><br>J. Kelley Avery, M.D.                |
| 449 | <b>Choosing an Investment Banker</b><br>Graham Smith   |
| 460 | <b>Golf CME Category I</b><br><i>Lifestyles</i><br>David Harshfield, M.D.                                  |

### DEPARTMENTS

- |     |                                       |
|-----|---------------------------------------|
| 452 | <b>AIDS in Arkansas Statistics</b>    |
| 455 | <b>Radiological Case of the Month</b> |
| 458 | <b>New Members</b>                    |
| 462 | <b>AMS Newsmakers</b>                 |
| 463 | <b>In Memoriam</b>                    |
| 464 | <b>Medicine in the News</b>           |
| 465 | <b>Electrocardiogram of the Month</b> |
| 466 | <b>Things to Come</b>                 |
| 468 | <b>Keeping Up</b>                     |

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# 1991: The Year in Medicine with Bold Predictions for 1992

Lee Abel, M.D.\*

I was once advised that a good reason to become a physician was that it would guarantee life would not be boring. The chance to help others, earn a comfortable income, and have a prestigious position in the community are certainly possible in many other occupations. How many of those occupations, though, can compare with medicine in terms of intellectual stimulation? For all the uncertainties now facing a medical career, medical students should be able to look forward to a very intellectually satisfying career.

This past year we saw a remarkable gain in our knowledge about disease and its treatment. We have come to see this progress as routine. An issue of *The New England Journal of Medicine* or *Annals of Internal Medicine* represents a truly impressive achievement, although I will admit I may not fully appreciate (euphemism for read) each issue. It is always important to maintain a healthy skepticism about the literature though, as the recent controversy over Amoxicillin in the treatment of otitis media demonstrates.<sup>1,2</sup> In addition to the articles which have furthered our knowledge, we also have the predictable articles written mainly to promote an academic career. For instance, there is the annual "coffee article." One year coffee is okay; the next year, use caution; and of course the ramifications about caffeinated vs. decaffeinated must be considered. Can the sub-group analysis of Espresso and Cappuccino drinkers be long in coming?

We have also come to expect that many medical and quasi-medical events will be big news in the "lay media." Our nation's preoccupation with health and the health care system is well known. As doctors, we have our own gauge about how "hot" a topic may be in the media, as evidenced by what particular patient concerns come to us. For example, I had many fewer patient visits for Lyme Disease Anxiety in 1991 than in 1990. In addition to causing the "disease of the month" syndrome, the media effect may also be quite apparent in regards to medication. In 1989, most patients had not heard of Prozac, in 1990 it often seemed most patients wanted to take it, while in 1991 no one wanted to. My idiosyncratic list of some of the "hot" medical topics in the news this past year would include:

1. President Bush developed atrial fibrillation which is found secondary to Grave's Disease (which curiously Mrs. Bush and their dog Millie also have).
2. Euthanasia and the Right to Die debate prompted by the actions of Dr. Jack Kevorkian and the ballot initiative in Washington State.
3. Wider recognition and discussion about Living Wills.
4. Senator Wofford's surprising victory in Pennsylvania which markedly accelerated the national debate about reforming the health care system.
5. Magic Johnson tests positive for HIV.
6. David Kessler and his reforms in the FDA including

---

\* Dr. Abel specializes in internal medicine and is affiliated with the Little Rock Diagnostic Clinic.



his aggressive campaign to make food labels readable and believable.

7. Studies documenting the adverse effect of network children's television with increasing viewing time being associated with obesity, higher cholesterol levels, and violent behavior.

Finally, an event which I will consider to be medical by virtue of his pen name; the death of Dr. Seuss, Theodore Seuss Geisel. Perhaps a good way to sum up the year in medicine is to paraphrase the conclusion of Dr. Seuss's wonderful book for adults, *You're Only Old Once!*, "Medicine is in pretty good shape for the shape that it's in."<sup>3</sup>

And of course, what is a year in review without some fearless predictions for the new year. So here goes my predictions for 1992:

1. The makers of *Jogging in a Jug* will expand their product line to meet intense consumer demand. Other useful activities (cycling, lap swimming, weight training, etc.) which should rightfully be available in a liquid form will soon be on your grocers shelves.
2. The University of Utah will announce the formation of a Center for the Development of Laparoscopic Gallbladder Transplantation (formerly the Center for Cold Fusion Research and Development).
3. The exponential growth in the number of new ACE inhibitors and Calcium Blocker drugs will be slowed only by the difficult task of coming up with catchy brand names.
4. Recently shown to be widely known to children as a "real smooth character,"<sup>4,5</sup> Old Joe the Camel will develop a bad hacking cough. His physician will worry that this signals the development of occult hump cancer.
5. The secret embalming fluid developed by Soviet scientists in the 1920's to preserve the body of Lenin will be sold in the West as a fountain of youth lotion. This effort by "new breed Russian entrepreneurs" will be very successful at generating much needed hard currency for the new Russian Republic.
6. The chronic fatigue syndrome will be found to be due to a mutation in a common cold virus. The mutation seems to occur when individuals with URI's watch more than 1.3 hours of daytime soap operas.
7. Several new NSAIDS will be marketed, bringing the total number of these drugs available to ap-

proximately equal the population of a medium-sized American city. Occasional patients will want to try them all.

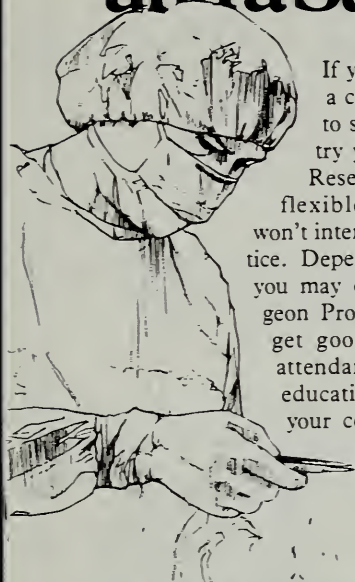
8. A new category of drugs will be created in pharmacology textbooks for drugs like Centoxin (monoclonal antibody to Endotoxin). This new class of drugs will be called "Drugs that are of no benefit 70% of the time they are used and cost as much as a new compact car." They will commonly be referred to as NOCAR's.<sup>6</sup>
9. In the continuing saga of breakthroughs in the transdermal delivery of medication, a major pharmaceutical company will announce the development of a weight loss drug delivered by a transdermal patch system. The patch seems most effective if worn over the mouth and replaced every 24 hours.
10. Researchers will report that watching the local news on TV is associated with an acceleration in Alzheimer's Disease. The issue of its role in the initiation of Alzheimer's will remain unsettled.
11. Millie will be found to have a severe tapeworm infestation. Fortunately, checks of President and Mrs. Bush will prove negative.

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# Ramipril: A review of the new ACE inhibitor

Tom P. Mills R.Ph.\*

*Ramipril is a long acting angiotensin converting enzyme (ACE) inhibitor, which exhibits similar pharmacodynamic properties to Captopril and Enalapril. Like Enalapril, it is a prodrug, which is hydrolyzed after absorption to form the active metabolite ramiprilat which has a long elimination half-life, permitting once daily administration. In the dose range 2.5-10 mg once daily the drug has been effective and well tolerated during treatment for up to two years. In dosages of 5 or 10 mg once daily the antihypertensive efficacy of Ramipril was comparable with usual therapeutic dosages of Captopril, Enalapril, and Atenolol.*

**I**t was not until the development of Captopril, the first orally administered ACE inhibitor, that treatment became available which could be widely used in clinical practice. ACE inhibitor therapy is now a valuable therapeutic option in the treatment of hypertension and congestive heart failure, and in some situations it is being considered as a first line choice.

Ramipril (Altace) marketed by Hoechst is a member of this drug class which bears structural similarities to Enalapril. In addition, both prodrugs are poor ACE inhibitors and are rapidly hydrolyzed after absorption to form the active ACE inhibitors ramiprilat and enalaprilat, respectively.

## Human Studies

The inhibitory effects of Ramipril on the renin-angiotensin-aldosterone system have been studied in

healthy subjects and in patients with hypertension or congestive heart failure. The acute effects of orally administered Ramipril in such studies included decreased plasma ACE activity, decreased plasma angiotensin II, increased plasma angiotensin I, increased plasma renin activity or renin concentration, and decreased plasma aldosterone concentration or urinary aldosterone secretion. The maximum inhibitory effect on plasma ACE activity was observed one to four hours after an oral dose of Ramipril 5-10 mg. Peak effects on plasma angiotensin I and angiotensin II levels, plasma renin activity and plasma aldosterone concentration occurred four to eight hours after administration. These changes were usually maintained when Ramipril was administered for two weeks, although plasma aldosterone concentration rapidly returned to pretreatment levels within several days.<sup>1</sup>

## Renal Effects

Tillman<sup>2</sup> studied the effects of long term oral administration of Ramipril 20 mg once daily in three hypertensive patients with unilateral renal artery stenosis. There were slight increases in serum potassium and urea, and no change in serum creatinine. Renal plasma flow on the stenotic side was changed only slightly but filtration fraction was reduced in two patients. These findings are consistent with studies of other ACE inhibitors in patients with renovascular hypertension in which there were reductions in both filtration fraction in the stenotic kidney and total filtration fraction. No consistent changes in glomerular filtration rate were observed. In patients with glomerulonephritis and nephrotic syndrome, low doses of Ramipril (1.25 mg or 2.5 mg every two days) administered for 24 weeks significantly reduced proteinuria and blood pressure without further deterioration in renal function.

\* Mr. Mills is a registered pharmacist with the Arkansas Children's Hospital in Little Rock.



## Pharmacokinetics

Ramipril may be administered in solution or as capsule or tablet formulations with little difference in its rapid rate of absorption. The mean peak serum concentrations of unchanged Ramipril and the active metabolite ramiprilat are reached in about one and three hours, respectively, in healthy subjects and hypertensive patients. The extent of Ramipril absorption and hydrolysis to ramiprilat appears to be similar over the dose range of 5-50 mg. Over the concentration range 0.01-10 mg/l Ramipril and ramiprilat are 73% and 56% bound respectively, to human serum proteins. The primary site of metabolism is the liver in which it is hydrolyzed, where de-esterification occurs. Only negligible quantities of unchanged Ramipril and its glucuronide conjugate were excreted in urine. The majority of renal excretion is accounted for by ramiprilat and its glucuronide conjugate. Both Ramipril and ramiprilat are metabolized to inactive diketopiperazine derivatives which are excreted in significant quantities in urine. The half-life during the major distribution/elimination phase ranges from 1.1 and 4.5 hours.<sup>3</sup>

## Therapeutic Trials

Most therapeutic trials of Ramipril have involved patients with mild to moderate essential hypertension. Few data have been published on its therapeutic efficacy in other indications.

## Essential Hypertension

The results of dose-finding and placebo-controlled studies of Ramipril in patients with mild to moderate essential hypertension show that oral administration of Ramipril 1.25-10 mg once daily as monotherapy reduced blood pressure by about 5-15%. Target blood pressure was obtained in about 50-70% of patients, a large placebo-controlled study identified a minimum effective dose of 2.5 mg, although the antihypertensive effect was greater with higher doses. Once daily doses of Ramipril provided adequate 24-hour control of blood pressure in patients with mild to moderate essential hypertension without altering the normal variation of blood pressure.<sup>4</sup>

The results of clinical trials comparing Ramipril with Atenolol, Captopril, and Enalapril will be discussed next. All these studies followed similar protocols. They were all randomized double-blind parallel group studies, included a four week run-in period on placebo to establish baseline, used the same end-points to determine antihypertensive efficacy, and enrolled large number of patients.

The antihypertensive efficacy of Ramipril 10 mg once daily was comparable to that of Atenolol 100 mg

once daily and Captopril 50 mg twice daily, and Ramipril 5-10 mg daily was comparable to Enalapril 10-20 mg once daily. The trials comparing Ramipril with Atenolol and Captopril were extended for a further six weeks, with nonresponders additionally receiving Hydrochlorothiazide 50 mg once daily. Regardless of the initial treatment, addition of a diuretic permitted about half of the nonresponders to reach the target supine and standing diastolic pressure of 90 mm Hg or less. Extension of these trials led to negligible additional decrease in blood pressure in the responders, who continued to receive monotherapy.

Adverse effects induced by Ramipril were of a similar nature to those induced by Captopril and Enalapril. Atenolol, however, caused more adverse effects than Ramipril, in particular myalgia, myasthenia, peripheral vascular disorders and lipid disorders. When administered in combination with the diuretic Hydrochlorothiazide, Ramipril, in common with other ACE inhibitors, attenuates or prevents the adverse effects associated with the thiazide diuretics.<sup>5</sup>

## Use in Severe Hypertension

Results from the first 70 patients enrolled in a non-controlled multicentre study of Ramipril in severe hypertension have been presented. After four weeks of antihypertension treatment (most were also on a diuretic plus a beta blocker plus a vasodilator) the mean blood pressure was 173/111 mm Hg. Ramipril 5-20 mg once daily was then added to the patients' regimens for eight weeks. After this period the mean blood pressure was 145/90 mm Hg. At the end of treatment 69% of patients had a diastolic blood pressure of 95 mm Hg or less. Six patients withdrew from the Ramipril phase of the study because of adverse effects. Ramipril 5-40 mg/day given either alone or in combination with other antihypertensive agents achieved blood pressure control in 18 of 20 patients with severe hypertension treated for 12 days.<sup>6</sup>

Thus, these preliminary results show that Ramipril may be effective as an add-on therapy in the control of severe hypertension.

## Renal Hypertension

Tillman<sup>2</sup> studied the effect of the relatively high dosage of Ramipril 20 mg once daily for one month in three hypertensive patients with unilateral renovascular disease. Twenty-four hours after the final dose of Ramipril there was a decrease in blood pressure, a slight increase in serum potassium and urea, no change in serum creatinine or glomerular filtration, and little change in renal plasma flow on the stenotic side. Filtration fraction was reduced in two patients. These preliminary data indicate that Ramipril may be effective in



patients with renovascular disease, but any definite conclusion awaits further clinical experience in this indication.

## Congestive Heart Failure

The acute hemodynamic effects of Ramipril have been examined in patients with congestive heart failure demonstrating significant reductions in mean arterial pressure, pulmonary artery pressure, pulmonary capillary wedge pressure and peripheral vascular resistance, and a significant increase in cardiac output. The results of this study therefore suggests that Ramipril administered once daily produces sustained hemodynamic changes in patients with severe congestive heart failure which are comparable to those produced by Captopril administered three times daily.

## Adverse Effects

Ramipril has been well tolerated in clinical trials. Adverse effects have generally been mild and transient, and only rarely severe enough to necessitate withdrawal of the drug. The nature, severity and frequency of adverse effects with Ramipril were similar to those of Captopril and Enalapril.<sup>7</sup> This is not unexpected as adverse effects with ACE inhibitors generally appear to be class specific. However, this does not rule out the possibility of idiosyncratic reactions with individual ACE inhibitors. Although dizziness/vertigo and headache were the most frequently occurring adverse effects associated with Ramipril, their incidence rates were below those observed with placebo. Other adverse effects reported were cough, rash and gastrointestinal disturbances, each occurring in less than 1% of patients. Taste disturbance occurred in only 0.1% of patients. It was also equally well tolerated in young and elderly patients with mild to moderate hypertension and administration for one year did not increase the risk of adverse effects. The clinically significant changes in lab values, such as BUN and serum creatinine, have occurred only rarely during Ramipril administration.

## Drug Interactions

Doering<sup>8</sup> found that co-administration of Ramipril 5 mg once daily for 14 days did not affect peak and trough serum Digoxin concentrations either during or after coadministration in 15 healthy subjects who were on steady-state Digoxin medication.

Other studies in healthy volunteers have shown that no pharmacokinetic interactions occurred between Ramipril and Hydrochlorothiazide or Furosemide when standard antihypertensive doses were administered. Three days of Indomethacin administration did not affect the pharmacodynamic or pharmacokinetic prop-

erties of Ramipril and finally, concomitant antacid administration did not affect the pharmacokinetic profile of ramiprilat.

## Dosage and Administration

The recommended starting dosage of Ramipril for the treatment of mild to moderate hypertension is 2.5 mg once daily in patients who are not already taking diuretics and who do not have renal failure or congestive heart failure. The dosage may be increased at intervals of one to two weeks up to a maximum of 10 mg daily to achieve an optimum therapeutic response. Ramipril is usually effective in the range 2.5-10 mg once daily. Patients who fail to satisfactorily respond to the maximum dosage should be given an additional antihypertensive agent, usually a diuretic.

To reduce the risk of symptomatic hypotension, a lower starting dosage of 1.25 mg daily in conjunction with close medical supervision should be used in hypertensive patients with congestive heart failure in the presence or absence of renal insufficiency.

The dosage of Ramipril should be reduced in patients with renal insufficiency. Treatment should start with 1.25 mg once daily when the creatinine clearance is less than 30 ml/min. Recommended maximum maintenance dosages are 5 or 2.5 mg once daily for patients with creatinine clearance values of 10-30 or less than 10 ml/min, respectively. Ramipril will be manufactured in the dosage form of a capsule which will have the strengths of 1.25 mg, 2.5 mg, 5 mg, and 10 mg.

## Place of Ramipril in Therapy

To establish the place in therapy of a new drug such as Ramipril requires the accumulation of considerable clinical experience. Nevertheless, the available data indicate that Ramipril will provide a useful alternative to other members of its class in the treatment of hypertension and congestive heart failure. This new ACE inhibitor does not show any real advantage over Enalapril, but does have a better side effect profile over Captopril. Time will tell about Ramipril's place in the therapy in the treatment of cardiovascular disease.

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**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

Additional information available to the profession on request.

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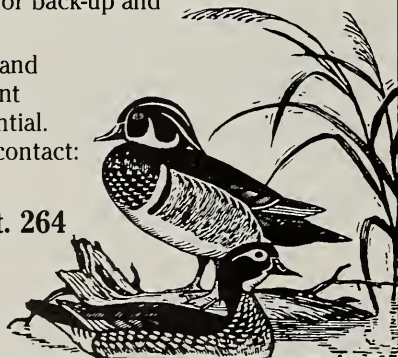
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CURRENT PROCEDURAL TERMINOLOGY

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SUPERBILL PPO

WORKMAN'S COMP

ICD DIAGNOSIS CODES

REFERRING PHYSICIAN SECONDARY

GROUP NUMBER HICFA

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MEDICARE

DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT

APPROVED AMOUNT TYPEWRITER

APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES

DATE OF DISABILITY

SELF PAYS MEDICAID ATTENDING PHYSICIAN PPO/HMO

RESPONSIBLE PARTY

DATE OF ACCIDENT

PATIENT RECORDS

INDIVIDUAL POLICY NUMBER



# RBRVS Medicare Physician Payment Reform

## A New Era in Payment Practices

**M**edicare physician payment reform, to be implemented in 1992, represents the most sweeping change in Medicare payment practices since the 1983 introduction of the hospital prospective payment system....

One thing history tells us is that Medicare is constantly changing and this new system, too, will immediately undergo amendments from both a legislative and regulatory process.

The following is a chronological review of the events leading up to the RBRVS and the activities of the AMA, its state affiliates, and the various specialty organizations.

### 1980s

Since the early 1980s, the American Medical Association has taken an aggressive leadership role in the search for an acceptable and equitable approach to paying for physician services furnished to Medicare patients.

### 1983

By 1983, with the start of DRG payment for hospitals, it was clear that Medicare's "customary, prevailing, and reasonable" (CPR) physician payment system would not long survive. With Medicare's problem of rapidly rising hospital costs apparently "solved," policy makers had turned to physicians.

### 1984

Senator Bob Dole declared 1984 the "year of the physician" — he was not handing out congratulations. It was clear that the next round of Medicare payment changes would be directed at physicians. The Reagan Administration and the Congress intensified the search

for alternatives to CPR, which they blamed for the rapid growth in federal outlays for Medicare physician payments in an era of growing budgetary strain.

The Administration focused on a wholesale shift from fee-for-service to "packaged" payment methods that controlled both price and volume. They were deadly serious, making a series of legislative and administrative proposals for physician DRGs and mandatory capitation, both of which would have included mandatory assignment.

At the same time, a physician payment schedule based on a new relative value scale (RVS) also emerged as a viable "reform." Unlike other proposals, the AMA and much of organized medicine believed that such a schedule could preserve fee-for-service, protect physicians' clinical autonomy, maintain patient access to quality medical care, and eliminate much of the complexity that increasingly plagued CPR. This complexity, and the payment distortions across specialties and geographic areas had created widespread dissatisfaction among physicians. The Association had concluded that change was not only inevitable; it was desirable.

### 1984-88

In 1984, the AMA met with HCFA and specialty societies to explore development of an RVS for Medicare. Given the growing concern within the AMA House of Delegates with the payment inequities underlying CPR, the AMA focused on a resource-based RVS, an RBRVS, which would reflect the resource costs of providing physician services (i.e., physician work, overhead, and professional liability insurance costs). Citing antitrust considerations, HCFA decided not to contract with a medical society. The AMA did, however, reach agreement with Professor William Hsiao at Harvard University as a subcontractor in his HCFA-



funded RBRVS study. This arrangement allowed for extensive involvement by organized medicine through both the AMA and over 20 specialty technical consulting groups whose members were nominated through the AMA by specialty societies.

Three months after the final report of Phase I of the RBRVS study was released, the AMA's House of Delegates adopted the position at its 1988 Interim Meeting that data from the Harvard study, when sufficiently expanded, corrected and refined, would provide an acceptable basis for an Medicare payment schedule. The House also adopted detailed policies on such implementation issues as protection of balance billings, geographic payment differentials, and Medicare expenditure controls.

### 1988

Immediately following the 1988 Interim Meeting, the AMA began advocating its positions on payment reform before the PPRC, Congress, HCFA, and the White House. In its April 1989 Report to Congress, the PPRC joined the AMA in supporting a Medicare physician payment schedule based on a refined Harvard RBRVS.

### 1989

Medicare physician payment reform legislation was passed in the fall of 1989 as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). This legislation mandated that a five-year transition to an RBRVS-based payment schedule begin in 1992. It reflected compromises by all parties concerned: physicians,

patients, Congress, and the Administration.

Largely through the efforts of the AMA and the Federation, the bill that emerged accomplished three primary goals: (1) it would implement a completed and refined RBRVS in a manner generally consistent with AMA policy; (2) it did not include mandatory assignment; and (3) it did not have a rigid expenditure target. The AMA's support for a completed RBRVS has helped stave off physician DRGs and mandatory capitation for nearly 10 years.

### 1990-91

Since OBRA 89, the RBRVS has had two additional phases. Many, although certainly not all, of the concerns raised by the AMA have committed to continuous RBRVS refinement and updating. Likewise, after an unprecedented campaign over proposed conversion factor reductions, the medical profession has secured a conversion factor that gives the new system a fighting chance. Finally, HCFA has begun to implement comprehensive standardization and simplification of the payment policies administered by its carriers.

### 1992

In sum, the AMA continues to believe that payment reform will still benefit physicians and their patients. The new system will be simpler and more uniform than the current system, will be implemented through a transition that minimizes disruptions to physicians and their patients, and provides needed relief for rural and primary care services. ■



## **MED-PAC**

### **Arkansas Medical Society**

### **Political Action Committee**

MED-PAC is the political voice for the Arkansas medical community, and we must support political candidates who best represent our concerns. Please join us and become a part of the solution.





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# The Loser Finally Wins

J. Kelley Avery, M.D.\*

**T**he "loser," a 28 year-old male, was seen with a history of gross bleeding from the urethra with some burning on urination. In the past, this young alcoholic had been treated for peptic ulcer disease and, eight years previously, had presented with a purulent urethritis typical of Gonorrhea. This had subsided with penicillin treatment but a urethral stricture developed which had caused some difficulty urinating and bleeding. A meatotomy and dilatation had been repeatedly recommended. On this admission, his general physical examination had been unremarkable including the prostate.

An IVP was done which showed moderate obstructive uropathy on the right secondary to a 3mm stone in the distal ureter about 3cm above the UV junction. The patient was discharged with a 10 day supply of Macro-dantin with instructions to return following the treatment. When he returned to his urologist, a meatotomy was done and the out patient record showed that the "stream improved."

Some five months later he was seen in the Emergency Room with marked epigastric pain, nausea and vomiting. On this occasion, his ETOH abuse was noted and he had a serum amylase of 571. Studies on this admission revealed cholelithiasis and some urethral obstruction. A diagnosis of acute pancreatitis was

made and he was discharged on a regime of diet, H2 blockers and NO ALCOHOL!

Two months following this admission, this loser was seen by his urologist. The office record shows "continues to complain of the same old problem; pain over the flanks and halfway down the penis." Treatment again was Macro-dantin. One week later the urine almost normal. One week later another IVP was done and showed an irregular calcification low in the right pelvis measuring some 6-7mm. "Mild obstructive uropathy present on the right." Again the patient was placed on Macro-dantin.

Three months later another IVP was done which showed no function on the right side for one hour, then marked hydronephrosis above a stone in the lower right ureter measuring about 1cm in diameter. There followed a traumatic extraction followed by the placement of a stint in the lower right ureter. Because of pain much more severe than usual, the stint was removed sooner than planned. He was discharged on Bactrim and Mepergan for pain.

Later the patient had to be admitted with severe abdominal pain. On this occasion, a pancreatic pseudocyst was diagnosed and surgically treated. A follow up IVP showed "mild to moderate hydronephrosis on the right."

Shortly after discharge, a suit was filed against the urologist charging unnecessary surgery, pain and suffering, and significant financial loss. A settlement in six figures was necessary in this case. No adequate defense could be developed.

---

\* Dr. Avery is chairman of the Loss Prevention Committee at State Volunteer Mutual Insurance Company in Brentwood, Tennessee and medical director of Ambulatory Services at St. Thomas Hospital in Nashville, Tennessee.



## Loss Prevention Comments

The cold medical record in this case makes settlement absolutely necessary! An obstructing stone in the lower right ureter was ignored for a year before definitive treatment was instituted. What factors could be present in this case that would have contributed to a good doctor overlooking the obvious in this way? Some possibilities come to mind:

- First, this was a very undesirable patient. He was a drunk who had first been encountered with gonorrhea, which had caused a urethral stricture.
- Second, he was a known alcoholic with physical complaints directly produced by his habit and he made no known effort to change his lifestyle.
- Third, he had multisystem complaints all seemingly related to ETOH and he was continually complaining of symptoms which he could have controlled or greatly moderated, but he would not.
- Fourth, the urologist in this case did the easiest thing in the world to do. He continued to attribute all this patient's symptoms to his known problem of urethral stricture, ignoring the more serious problem. In all probability, the urologist, who routinely read his own x-rays did not take note of the radiologist's reading of a stone a year before its extraction.
- Fifth, after the repeat study showed the stone to have enlarged and the obstruction to have become more marked, it was three months before intervention. This delay had to be due to some oversight or "falling through the cracks."

Perhaps the most evident trap in this case is the trap of the extremely undesirable, obnoxious patient. Maybe this man deserved his fate, but not at the expense of his doctor. Yes, this loser really did win! ■

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Most people agree that the U.S. health care system needs significant change. And if a single-payor, national system is adopted, it will change.

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If you find these kinds of changes hard to swallow, maybe you should support a proposal that will build on what's good about America's health care system. And change what's not. A plan like Health Access America.

Developed by the American Medical Association, Health Access America was designed to preserve the integrity of the system while improving programs like Medicare and Medicaid, and requiring employer-sponsored health plans.

So while there's still time, speak for yourself. Join the AMA's call for reform. Call 1-800-AMA-3211 for more information on Health Access America.

## Health Access America

The AMA proposal to improve access to affordable, quality health care.

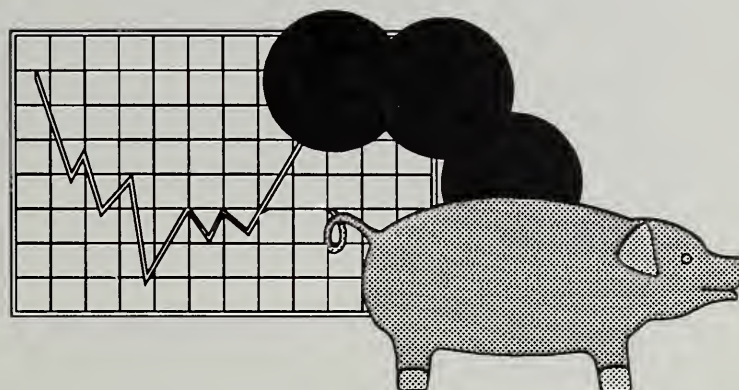
## American Medical Association

Physicians dedicated to the health of America





# Choosing an Investment Broker



Graham Smith\*

**S**izable portfolio's - whether for individuals or institutions - require well informed and timely investment decisions. Failing to get information about a company or an offering before investing in it is the single most common mistake made by investors. Errors such as this can make the difference between a winning and losing strategy.

There are three important ingredients each individual should address when managing a portfolio.

The first ingredient needed is a basic knowledge of how to properly invest money and how basic investment vehicles operate. You need to know about stocks, bonds, and other investment vehicles and how interest rate fluctuation and our economic cycles effects each.

Secondly, you must have the resources to get timely and correct information about those opportunities in which you have an interest. Having no information about a stock you want to buy can be a costly mistake. Some investors actually buy stock in a company without knowing about the company's product or what its future might be.

The last ingredient needed is time. You must dedicate the proper amount of time to administration and research to make sure you are making prudent investment decisions. This is the most important, yet scarce component in the mix. Between work schedules, social and family commitments, time does not exist for most people to properly manage their investments on their own. However, several alternatives exist to help with the day-to-day management of investments.

## Getting Advice

In today's society, you can get as much investment advice and help as you feel necessary. The most common service used is that of an investment broker.

Brokers can differ in several ways. There are full-service and discount firms; there are national, regional and local firms. All sell more than just stocks; they sell municipal bonds, unit trusts, tax shelters, annuities and many more investments. But when you get right down to it, the chief distinction lies between the full-service and discount firms.

### *Discount Brokers*

Here you get execution of your order - no research, no hand-holding, no advice (although some firms do make helpful literature available). Salespeople are paid a salary, not commissions, and simply take orders to buy or sell securities. No advice is provided upon individual issues or your overall investment strategy.

### *Full-Service Brokers*

Full-service firms offer a wide range of customer services, including research reports, individual attention, asset-management, consolidated statements and seminars on retirement planning, tax shelters and other investment-related topics.

In most situations, an individual broker will work personally with you to decide on those investments best suited for your individual needs. Brokers may be called account executives, financial consultants or some other title. Through your broker, you are provided with access to a small army of research analysts who study firms and industries in search of good invest-

\* Mr. Smith is a financial consultant with Merrill Lynch in Little Rock, Arkansas.



ments and pass along their recommendations. The need for a good broker is imperative.

### How to Pick the Right Broker

For many investors, their broker is the single most valuable source of help in setting up their portfolio and making investment decisions. However, an inept or unresponsive broker can make life miserable, as well as cost money. The choice of an investment broker can make the difference in a successful portfolio.

Choosing an investment broker is similar to interviewing someone for employment, evaluating them on their knowledge, skills and attitude. You are employing the broker, on a commission or fee basis, to provide you with the necessary information to develop a winning investment strategy.

When interviewing a broker, it is important to find out his investment philosophy. How does he work with his clients? What investment devices does he use? How much risk will he take to achieve the goals you

have given him? What is his educational experience? How long has he been in the investment business? What is his investment success rate? Ask to see sample accounts of how the broker has invested other peoples money. You can get some valuable insights by asking the broker for referrals of current clients and asking their opinion of the broker's ability.

It is important to find out as much as you can about the broker so that you feel comfortable with him and his ability to handle your money. By asking these and other questions, you will develop a sense of trust and teamwork with the investment advisor you choose.

Investing today will give you the opportunity to plan for your needs later in life. By getting expert help and taking a long-term approach, you can make your money work for you.

*This is the second in a series of articles that will discuss the various steps for investing in the 90's.*



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# Arkansas HIV/AIDS Report

## 1983-1991

### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who Is Required to Report HIV/AIDS

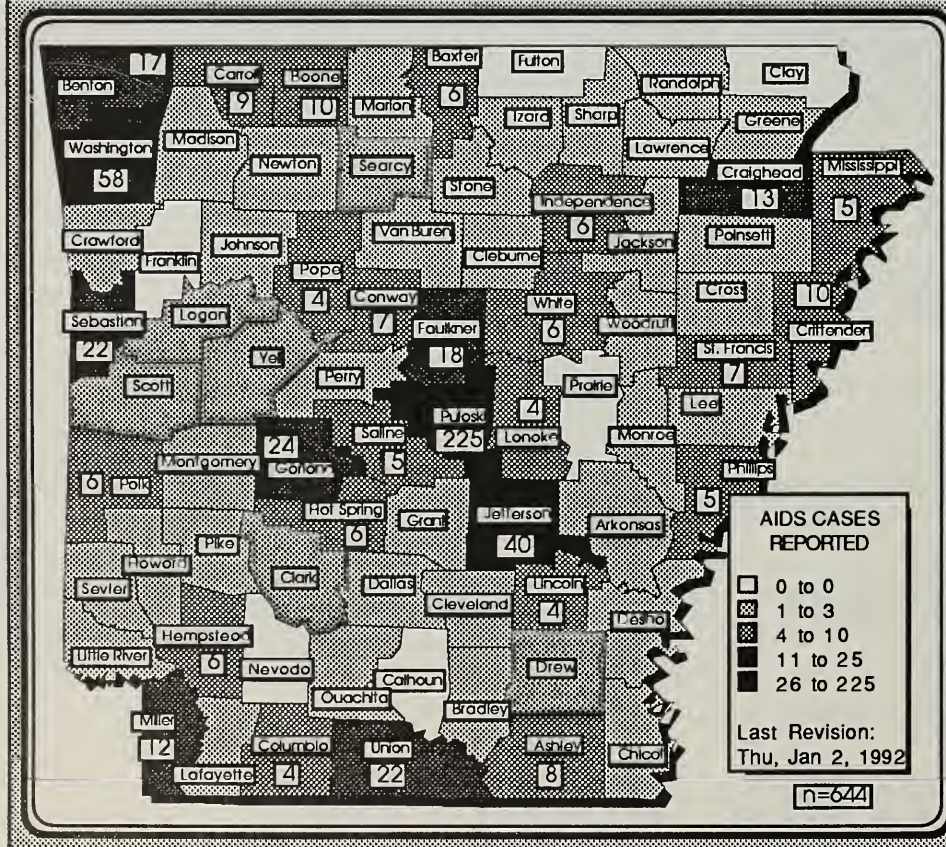
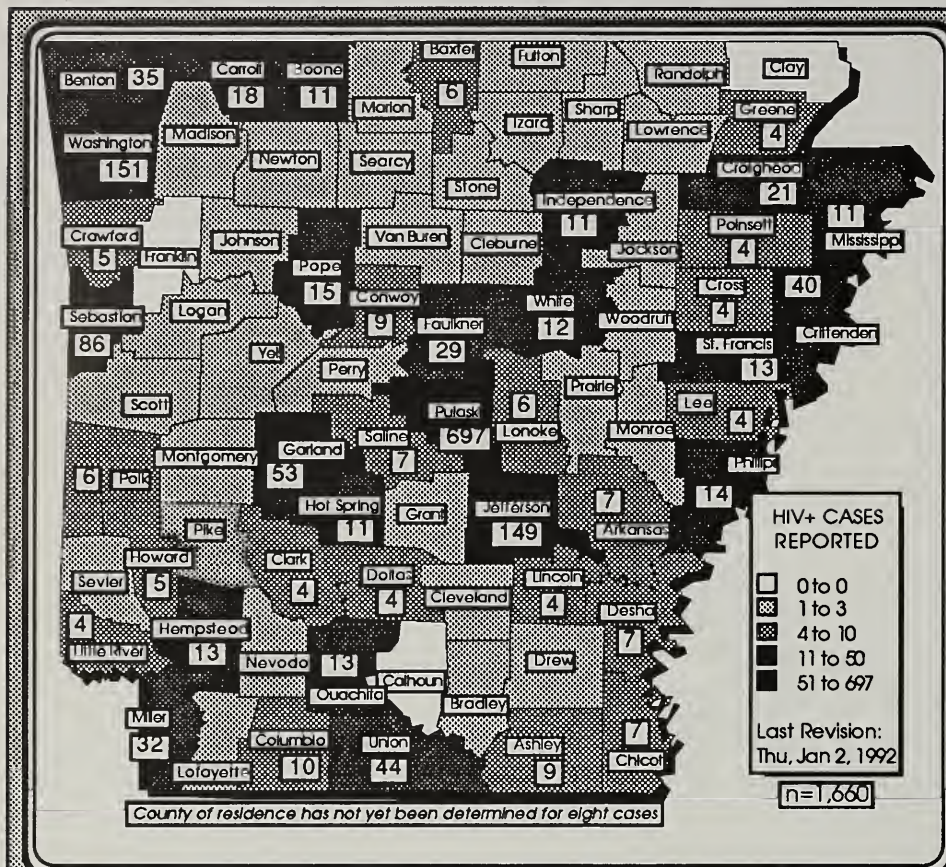
- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.





# Arkansas AIDS Report

## 1983-1991

Arkansas: June 1983 - December 31, 1991

HIV		1983-5	1986	1987	1988	1989	1990	1991	Total	%
S E X	Male	19	32	49	216	251	438	420	1,425	85.84
	Female	1	1	6	27	39	71	90	235	14.16
A G E	< 5	0	0	1	1	2	8	13	25	1.51
	5-12	0	0	0	1	1	5	1	8	0.48
	13-19	0	0	0	8	8	14	20	50	3.01
	20-29	8	10	15	109	124	192	151	609	36.69
	30-39	7	15	22	86	105	206	212	653	39.34
	40-49	4	7	11	24	35	61	71	213	12.83
	> 49	1	1	6	8	12	19	24	68	4.10
	Unknown	0	0	0	6	3	4	19	34	2.05
R A C E	White	16	24	47	171	177	353	309	1,097	66.08
	Black	4	8	8	70	107	152	195	545	32.83
	Other	0	0	0	2	6	4	6	18	1.08
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	1,660	100%

AIDS		1983-5	1986	1987	1988	1989	1990	1991	Total	%
S E X	Male	11	22	46	77	70	170	176	578	89.75
	Female	1	0	4	6	10	20	25	66	10.25
A G E	< 5	0	0	0	1	1	6	6	14	2.17
	5-12	0	0	0	1	0	1	1	3	0.47
	13-19	0	0	0	0	0	4	3	7	1.09
	20-29	1	0	15	27	24	55	57	194	30.12
	30-39	3	13	23	36	41	78	80	274	42.55
	40-49	1	0	8	10	7	35	41	108	16.77
	> 49	1	0	6	8	7	11	13	44	6.83
R A C E	White	9	22	43	61	58	141	134	468	72.67
	Black	3	6	7	20	21	47	66	170	26.40
	Other	0	0	0	2	1	2	1	6	0.93
R I S K	Homosexual/Bisexual	7	17	31	59	50	118	116	398	61.80
	IV Drug User	0	2	10	4	11	18	28	73	11.34
	Homo Male & IVDrug Use	3	9	4	6	6	18	17	63	9.78
	Heterosexual	2	0	2	3	6	10	10	33	5.12
	Transfusion	0	0	2	7	3	7	11	30	4.66
	Perinatal	0	0	0	1	7	8	6	14	2.17
	Hemophiliac	0	0	0	1	7	5	5	12	1.86
	Undetermined	0	0	1	2	2	8	8	21	3.26
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	644	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.

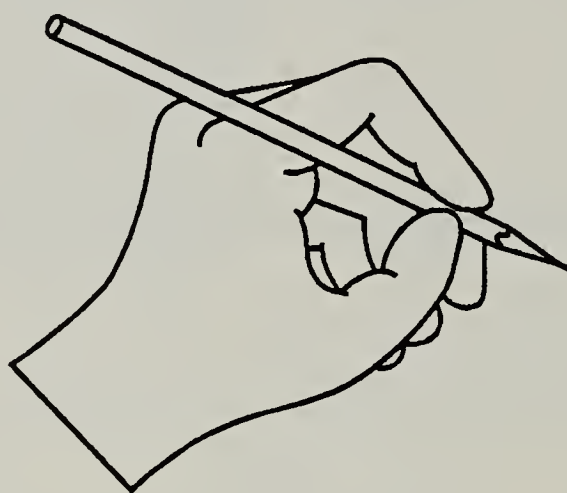


# Topics in Search of Authors

You can influence your peers - and give something back to your profession - if you plan to write an article for *The Journal of the Arkansas Medical Society*.

*The Journal* needs your thoughts and ideas. So why not consider putting your expertise on paper? Here are some of *The Journal's* topics in search of an author.

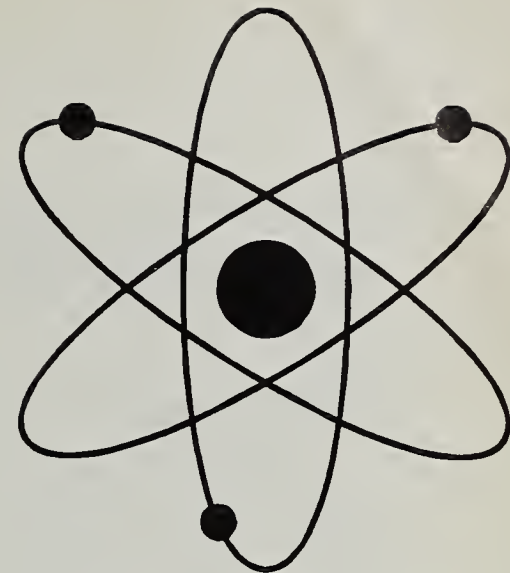
- Practice management for today's physicians
- Coping with difficult patients
- Women's health issues
- Teens and drug use
- Medicare/Medicaid issues
- Medical ethics and health care
- What's the value of organized medicine?
- New treatments and technology
- Cutting the belt on health-care costs
- Medical history of Arkansas
- A smokeless society
- A doctor's hobby
- Medicine of the future
- Waste management update
- How to market your practice
- Access to care for the indigent
- Erosion of the physicians' image



For more details, call or write:  
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*The Journal of the Arkansas Medical Society*  
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# Radiological Case of the Month



Joseph S. Murphy, M.D.  
Debra F. Morrison, M.D.  
Paul K. Osteen, M.D.  
Steven R. Nokes, M.D.  
David L. Harshfield, M.D.

## History:

This 70-year-old male presented with intermittent abdominal pain.



Figure 1a. Flat and Erect Abdomen.



Figure 1b. Flat and Erect Abdomen.

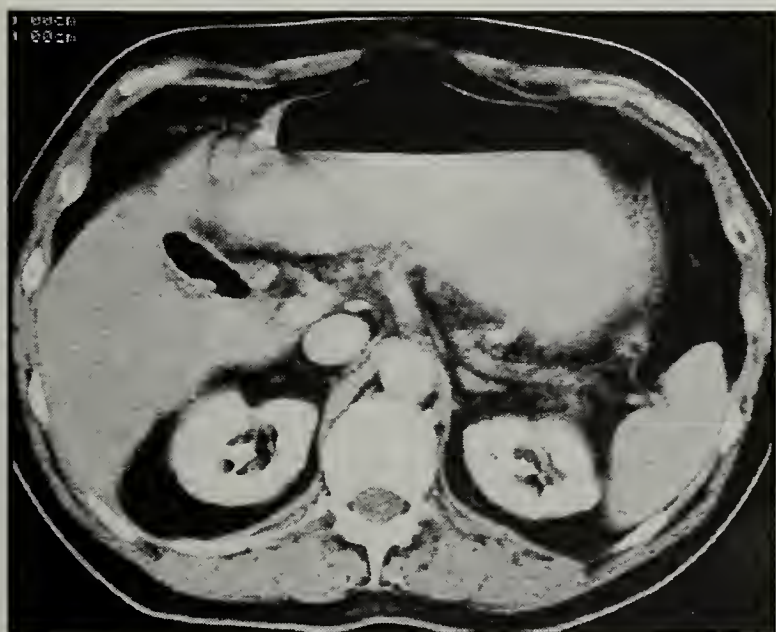


Figure 2a. CT scans of upper and lower abdomen.



Figure 2b. CT scans of upper and lower abdomen.



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# Gallstone ileus

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## Radiographic Findings:

Flat and erect views of the abdomen reveal gas in the gallbladder and dilated, predominately fluid-filled small bowel loops. The ectopic gallstone, overlying the pelvis, is not definitely seen. Figure 2a confirms gas within the gallbladder lumen. Figure 2b demonstrates dilated fluid-filled small bowel loops and a laminated intraluminal calculus.

## Discussion:

Spontaneous communication between the biliary tract and intestine is the result of erosion of a gallstone in 90% of cases. Ninety percent of these gallstones pass spontaneously without causing symptoms. However, if the gallstone is sufficiently large and/or there is predisposing stricture or spasm, an intestinal obstruction (gallstone ileus) may be produced.

It is said that of all intestinal obstructions, gallstone ileus accounts for 2% of obstructions and is the most insidious and difficult to diagnose clinically. The mortality is five times that of any other small bowel obstruction. The average of these patients is 69 years. Approximately 88% of patients afflicted are women.

The biliary-intestinal fistula involves the duodenum in approximately 60% of cases. The intestinal obstruction usually occurs in the terminal ileum at the ileocecal valve (60% of cases). The obstruction may be constant or intermittent.

The cardinal plain film radiographic findings are: dilated fluid-filled loops of small bowel, air in the biliary tree or gallbladder is visible in nearly two-thirds of patients with gallstone ileus. A gallstone in an ectopic location is seen in between one-fourth and one-half of patients. Though often difficult to interpret, gas in the gallbladder and biliary tree may be seen with ultrasound in the form of a "dirty" shadow. Axial CT images are ideal for demonstrating both ectopic gas and stones. Bowel obstruction is well demonstrated by CT also.

## References

1. Margulis AR, Burhenne HJ. Alimentary Tract Radiology, Fourth Edition, 1989; pgs. 1215-1216.
2. Berk RN, Ferrucci JT, Leopold GR. Radiology of the Gallbladder and Bile Ducts, 1983; pgs. 22-28.
3. Eisenberg RL. Gastrointestinal Radiology: A Patter Approach, Second Edition, 1990; pg. 490.

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*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is director of CT/MRI for Radiology Consultants in Little Rock.*

*Contributor: Joseph S. Murphy, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Debra F. Morrison, M.D., is affiliated with Gastroenterology Associates of Little Rock.*

*Contributor: Paul K. Osteen, M.D., is affiliated with the Surgical Clinical in Little Rock.*



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# New Members

---

## BOONE COUNTY

**Padilla Jr., Jose S.**, General Surgery, Harrison. Born, December 23, 1958, Mayaguez, Puerto Rico. Medical education, University of Puerto Rico School of Medicine, San Juan, 1984. Internship/residency, Mayaguez Medical Center, Puerto Rico, 1989. Practice experience, 2 years. Board eligible.

## CRAIGHEAD/POINSETT COUNTY

**Hoke, Wallace S.**, Family Medicine, Jonesboro. Born, September 4, 1961, Memphis, TN. Medical education, UAMS, 1987. Internship/residency, AHEC-Northeast, Jonesboro, 1990. Practice experience, 1 year. Board certified.

## GREENE COUNTY

**Brown, Peggy J.**, Neurology, Paragould. Born, September 19, 1951, Springfield, IL. Medical education, Chicago School of Medicine, North Chicago, IL, 1985. Internship, Mac Neal Memorial Hospital, Berwyn, IL, 1986. Residency, Vanderbilt University, Nashville, TN, 1989. Practice experience, 4 years. Pending certification.

## JEFFERSON COUNTY

**Marcus, Herschel C.**, Family Practice, Pine Bluff. Born, February 18, 1945, Birmingham, AL. Medical education, SUNY - Upstate Medical Center, Syracuse, NY, 1977. Internship/residency, Methodist Hospital, Indianapolis, IN, 1980. Practice experience, 11 years.

## PULASKI COUNTY

**Casteel, Helen B.**, Pediatrics, Little Rock. Born, February 21, 1953, Tupelo, MS. Medical education, Texas Tech, Lubbock, 1976. Internship/residency, UAMS, 1982. Practice experience, 9 years. Board certified.

## WASHINGTON COUNTY

**Mullis, Ronald J.**, General Surgery, Fayetteville. Born, November 16, 1959, Camp Springs, MD. Medical education, UAMS, 1986. Internship/residency, University Hospital, 1991. Board eligible.

**Whitney, Richard N.**, Emergency Medicine, Fayetteville. Born, July 13, 1953, Syracuse, NY. Medical education, University of Texas Southwestern Medical School, Dallas, 1978. Internship/residency, UMKC Truman Medical Center, Kansas City, MO, 1981. Practice experience, 9 years. Board certified.

## RESIDENT

**Ramsey, D. Bruce**, Neurology, Little Rock. Born, March 31, 1962, Alexandria, LA. Medical education, Texas Tech University Health Science Center School of Medicine, Lubbock, 1988. Internship/residency, UAMS.

## MEMBERS-AT-LARGE

### *Hot Springs*

**Gerber, Allen D.**, General Surgery. Born, October 30, 1948, Harper, KS. Medical education, University of Kansas, Kansas City, 1974. Internship/residency, Wesley Medical Center, 1978. Board certified. Practice experience, 11 years.

### *Fayetteville*

**Pickhardt, Mark G.**, OB/GYN. Born, February 28, 1961, Little Rock. Medical education, UAMS, 1987. Internship/residency, University of Mississippi, 1991. Board eligible.

**Ratcliff, David G.**, Internal Medicine. Born, October, 17, 1958, Little Rock. Medical education, Vanderbilt Medical School, Nashville, TN, 1985. Internship/residency, University of Colorado, 1988. Board certified. Practice experience, 2 years.

### *Fort Smith*

**Steward Jr., Rodney D.**, Anesthesiology. Born, April 26, 1960, Oklahoma City. Medical education, University of Oklahoma, Oklahoma City, 1982. Internship, University of Kansas, 1987. Residency, UAMS, 1990. Practice experience, 1 year.

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**Torres, Stephen E., OB/GYN.** Born, April 4, 1955, Tulsa, OK. Medical education, University of Oklahoma College of Medicine, Oklahoma City, OK, 1982. Internship, St. Joseph Medical Center, Phoenix, AZ, 1983. Residency, UAMS, 1987. Board certified. Practice experience, 3 years.

#### *Nashville*

**Hopson, Deanna L., Emergency Medicine.** Born, December 16, 1961, Little Rock. Medical education, UAMS, 1988. Internship/residency, AHEC, Fort Smith, 1991. Board certified.

#### *North Little Rock*

**Tielens, Don R., Anesthesiology.** Born, May 5, 1932, Memphis, TN. Medical education, University of Tennessee College of Medicine, Memphis, 1961.

Internship, Baptist Memorial Hospital, Memphis, TN, 1962. Residency, City of Memphis Hospital, 1976. Practice experience, 29 years.

#### *Pine Bluff*

**Augustine, Paul, Internal Medicine/Nephrology.** Born, May 3, 1955, Cochin, India. Medical education, St. Johns Medical College, Bangalore, India, 1982. Internship/residency, Coney Island Hospital, Brooklyn, NY, 1988.

#### *Texarkana*

**Chandler, Rodney R., Emergency Medicine & General Practice.** Born, May 9, 1947, Texarkana, TX. Medical education, UAMS, 1973. Internship, Charity Hospital of Louisiana, New Orleans Tulane Division, 1974. Practice experience, 17 years.



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# Golf CME Category I

David Harshfield, M.D.\*

As many of us become more cognizant of quality of life issues (such as maintaining our mental health), we are confronted with which recreational activities to prescribe ourselves for therapy. For some reason, many of us have become interested in golf, thinking that this will be a relaxing way to spend our limited playtime. What most of us have discovered, however, is that if left to own devices, golf is very difficult to master. Since most of us in the health care profession are trained students, our learning skills are well developed. Therefore, if given the proper information, we should be able to assimilate and excel at practically anything—even golf.

Golf is an engaging activity because it is so different from most other sports. It is one of the few sports we play where we do not watch the target, but instead must concentrate on the ball. In basketball, for instance, you look at the goal as you shoot. In football, you must watch the receiver as you pass the ball. In shooting, your eye must also be on the target. In other words, we find it difficult to play

golf when it is based on principles and techniques totally different from most other sports with which we have experience. What has been interesting to me personally is that so many of us reach a certain level in golf,

and never significantly lower our handicap thereafter. Most of us are capable of making par on any given hole during a round. For a number of reasons (usually mental lapses or faulty swing mechanics which produce inconsistency), we have a couple of bad holes and our scores soar. Most of us could markedly improve our games if we were informed of both proper swing techniques and the proper shot strategies.

Anyone who has ever played blackjack

or any other game of chance knows that to be successful you must play the odds and understand the probability of certain outcomes. All of us know that good scores in golf are not a matter of how good your good shots are, but how good your bad shots are. All of us could make pars if we hit only good shots. Unfortunately, we rarely hit good shots and more often we hit not so good golf shots. To lower our score, we must learn not only how to reduce the odds of hitting bad shots, but increase the chances of making pars when we do.

Most of us have pursued careers which were based on our ability to focus on a body of knowledge, learn



*Dr. Harshfield taking a swing at the Hot Springs Country Club during the 1991 AMS Annual Convention Golf Tournament*

\* Dr. Harshfield is chief of the radiology service at the Veterans Administration Hospital, Little Rock, and head of radiology at Riverside Radiologist Group, North Little Rock.



that information, and then incorporate that into our profession. We are all very familiar with long hours of solitude, pouring over classnotes and textbook chapters in pursuit of knowledge. Maybe that is why some of my most relaxing moments have been spent at the practice range or around the putting green, by myself, concentrating on the fundamentals and techniques of a particular aspect of my golf game. Many times this has been in the late afternoon accompanied by a warm sunset. For a short while, I forgot all the distractions and stress in my life. Those moments were especially enjoyable because not only did they allow me to relax, but they satisfied the ever present obsessive-compulsive gremlin in my personality. With time being so precious, most of us have personalities which frown on spending it frivolously. However, if we spend it in endeavors which result in self improvement (golf improvement), we can justify the time spent in the practice area and on the golf course.

In my personal experience, my game was at its best in college when I played mostly with natural ability and very little knowledge of the golf swing or proper strategies. After medical school, residency, and starting my practice, I became interested in returning to competitive golf. I am finding that by simply practicing, no matter how diligently, I have been unable to improve my game on my own. After playing in a tournament

recently with a young professional, Mike Hammond, and discussing in depth his philosophy about golf strategy and the golf swing, I have become a student of golf probably for the first time in my life. Mike has been able to take my golf swing and explain to me its strengths and weaknesses. In addition, he has taught me the proper methods of several different types of golf shots. Now when I spend time in the practice range, I am practicing proper techniques and this is resulting not only in relaxation, but in marked improvement in my game. Since those of you reading this are good students, you should be able to assimilate Mike's techniques and strategy into your golf game as well.

I thought it might be a good idea to share some of Mike's expertise and knowledge about golf with others around the state by having a periodic golf lesson in *The Journal*. Mike will tell you that the fastest way to lower your handicap is to improve your short game, and thus the first lesson will be concerning chipping. I hope you enjoy these golf tips which will be published from time to time. If you can incorporate Mike's philosophy into your game, I can assure you that you will lower your handicap. Remember no matter how much you practice, if you practice the wrong thing, you will never improve. If you practice the techniques Mike proposes, you will be amazed at your improvement. Good Luck! and Good Golfing!

## Golf Tips

*Mike Hammond  
Assistant Golf Professional  
Chenal Country Club, Little Rock*

By definition the chip shot is a low running shot usually used closely around the green. If you practice proper technique and use your imagination hopefully you should start getting the ball up and down almost every time. Here are some keys I use when chipping.

1. Try to land the ball 3 to 6 feet on the green. Then, depending on how far away the pin is will determine which club I select. I may use a sand wedge or wedge if the pin is close to the edge of the green or use a 7 to 5-iron if the pin is further back. It depends how far I want the ball to roll. When you practice, don't be afraid to use several different clubs while chipping.

2. Position your feet fairly close together and slightly open to the target line.
3. Position your weight on your left side. Lean left and stay there throughout the entire stroke.
4. Position the ball off your right toe, or back in your stance. This ball position should put your left hand in front of the ball, or your left hand should be even with your left thigh.

In gripping the clubs, for a chip shot, I usually use my putting grip. The stroke should be similar to the putting stroke controlled by your shoulders and less hands. The more handsy the stroke, the less control you'll have with the distance.

**Good luck! And practice, practice, practice.**



# AMS Newsmakers

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**Dr. Verona T. Brown**, a Batesville family physician, has been elected to the board of directors of Worthen National Bank at Batesville.

**Dr. Jerry Byrum**, a Little Rock pediatrician, has been elected to fellowship in the American Academy of Pediatrics.

**Dr. J. Roger Clark**, director of Arkansas Sports Medicine & Orthopaedic Center, P.A. in Little Rock, will serve on the medical committee of the board of directors with the Arkansas Special Olympics.

The **Craighead-Poinsett Counties Medical Society** has made a generous contribution to initiate a medical student scholarship at the University of Arkansas for Medical Sciences College of Medicine. Warren Skaug, M.D., president of the society, recently presented a check to I. Dodd Wilson, M.D., dean of the College of Medicine.

The scholarship will be awarded in honor of Dr. Joe Verser's 54 years of service to the medical profession in Arkansas.

**Dr. Craig Ditsch**, who practices general medicine in Texarkana, was chosen the 1991 Physician of the Year for Homestead Manor.

Dr. Ditsch is the personal physician to the majority of the residents and regularly visits the home and it's residents to assist in their health care.

## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of November and December are:

Susan W. Balke  
George H. Brenner  
Donald G. Browning  
Jerry C. Holton  
Steven R. Nokes  
Terrence R. Yates

Marianna  
Little Rock  
Little Rock  
Little Rock  
Little Rock  
Searcy

**Dr. Doug Maglothin**, a Jonesboro family physician, has been elected to the board of trustees of Crowley's Ridge Academy in Paragould.

**Dr. Mary R. McCalla**, of Memphis/West Memphis, has been elected to fellowship in the American College of Surgeons.

**Dr. Barry Thompson**, a family physician from Crossett, has been elected to the board of directors of the American Cancer Society, Arkansas Division.

**Dr. Steve Woodruff**, a Jonesboro family physician, has been elected to the board of trustees of Crowley's Ridge Academy in Paragould.

## SOUTHERN INDEPENDENCE

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*Cheraw, South Carolina 29520*  
*(803) 537-2171. Call collect.*



# In Memoriam

---

## **Robert H. Atkinson, M.D.**

Dr. Robert H. Atkinson, a retired family practitioner from Hot Springs, died Wednesday, December 18, 1991. He was 75.

Dr. Atkinson was a member of the American Medical Association, an emeritus member of the Arkansas Medical Society, and a member of the Garland County Medical Society.

Survivors are his wife, Moye Atkinson; two sons, Pat Atkinson of Olympia, Wash., and Jack Atkinson of Denver, Colo.; a daughter, Mary Claire McGarry of Houston, Tex.; and eight grandchildren.

## **Thomas F. Dilday Jr., M.D.**

Dr. Thomas F. Dilday Jr., of Sante Fe, N.M., formerly of Little Rock, died Tuesday, December 31, 1991. He was 66.

Dr. Dilday was a member of the American Medical Association and a former member of the Arkansas Medical Society.

Survivors are his wife, Floy B. Dilday; five sons, Thomas F. Dilday III of Corpus Christi, TX, Joseph T. Dilday and John J.T. Dilday, both of Tampa FL, Dr. James C. Dilday of Little Rock and Anthony T. Dilday of Boston, MA; a brother, Joe T. Dilday of Little Rock; a sister, Rosemary Dilday of San Diego; and three grandchildren.

## **Ray W. Leavelle, M.D.**

Dr. Ray W. Leavelle, a radiologist from Texarkana, died Saturday, January 4, 1992. He was 46.

Dr. Leavelle was a member of the Arkansas Medical Society and the Miller County Medical Society.

Survivors are his wife, Rene Leavelle; a son, Lincoln Leavelle of Texarkana; two daughters, Lynda Leavelle and Laura Leavelle, both of Texarkana; his mother, Beverly L. Leavelle of Texarkana; a brother, Dr. Lurry Leavelle of Temple, TX; five sisters, Joyce Fulmer, Gayle Flanagan, Betty Norton, Jane Scott and Lisa Mauk, all of Texarkana.

## **George E. Mitchell, M.D.**

Dr. George E. Mitchell, a retired physician from Fort Myers, Flor., died Friday, November 15, 1991. He was 69.

Dr. Mitchell was a member of the American Medical Association, an emeritus member of the Arkansas Medical Society, and a member of the Craighead-Poinsett County Medical Society.

Dr. Mitchell is survived by his wife Elizabeth Mitchell.

## **Doane M. Newton, M.D.**

Dr. Doane M. Newton, a pediatrician from Hot Springs, died Tuesday, January 7, 1992. He was 52.

Dr. Newton was chief of the department of pediatrics at AMI National Park Medical Center, past president of the board of Ouachita Regional Counseling Center, a fellow with the American Academy of Pediatrics and past president of its Arkansas chapter, and a diplomat with the American Board of Pediatrics.

He was also a member of the American Medical Association, the Arkansas Medical Society, and the Garland County Medical Society.

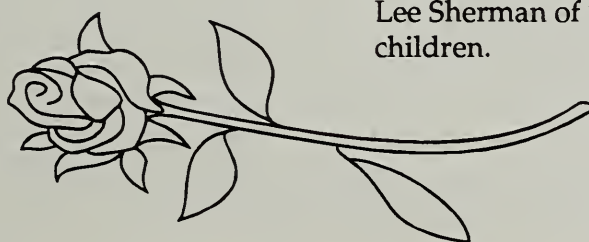
Survivors are his wife, Rebecca Jo Newton; a son, Ben Newton of Conway; two daughters, Sissi Newton and Becka Newton, both of Hot Springs; a brother, Albert Newton of Springdale; two sisters, Donna Langlais of Little Rock and Margaret Smith of Harrisburg; and two grandchildren.

## **Robert L. Sherman, M.D.**

Dr. Robert L. Sherman, a gynecologist from Fort Smith, died Saturday, January 4, 1992. He was 66.

Dr. Sherman was a member of the American Medical Association, the Arkansas Medical Society, and the Sebastian County Medical Society.

Survivors are his wife, Patrece Sherman; two sons, Scott Sherman of Corpus Christi, TX, and Tony Sherman of Little Rock; two daughters, Janet Looney and Nancy Sherman, both of Little Rock; a brother, Lee Sherman of Scarsdale, N.Y.; and four grandchildren.





# Medicine in the News

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## Health Care Access Foundation Update

As of January 1992, the Arkansas Health Care Access Foundation has provided free medical services to 3,407 medically indigent persons.

The program has 1,463 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## AFMC Recruiting Physician Advisors

The Arkansas Foundation for Medical Care is seeking physicians to review medical records. Physician Advisors are needed to perform peer review in numerous medical specialties and subspecialties. Physician Advisors are also called upon to participate in criteria development and to otherwise assist in interpreting acceptable standards of medical practice within the state.

The need for more reviewers is heightened by PRO contract requirements to match the specialty of reviewing physician to that of the attending physician when quality of care issues are involved. The AFMC also tries to assure that reviewing physicians practice in similar settings to the physicians whose care they are reviewing. Only by having adequate representation of the various specialties and urban/rural practices can we effectively ensure true peer review.

Physician consultants must be Foundation members, must be in good medical staff standing at

their respective hospitals, and must not have significant adverse practice patterns identified through AFMC review programs.

Physicians interested in becoming reviewers for the AFMC, should contact Morton C. Wilson, M.D., P.O. Box 2424, Fort Smith, AR 72902-2424; or 1-800-272-5528, extension 219 (outside the Fort Smith calling area) or (501) 785-2471, extension 219 (inside the Fort Smith calling area).

Physicians interested in becoming members of the AFMC, or unsure of their membership status, should contact Patricia Williams, Administrative Assistant to the board of directors, either in writing or by telephone. Her extension number is 261.

## Updated Statements on Delineation of Hospital Privileges

The American Medical Association's Department of Hospital Medical Staff Services has updated the Statements on Delineation of Hospital Privileges, a compilation of statements and/or guidelines on delineation of hospital medical staff and clinical privileges developed by national medical specialty societies and by the professional associations of dentists and podiatrists. Its purpose is to provide hospital medical staffs and others with the various statements that are available on the delineation of clinical privileges for the performance of diagnostic and therapeutic procedures utilizing recent advanced technology.

## Equipment For Sale

1984 Olympus OSF primary care sigmoidofiberscope with standard accessories and CLK-3 simplified light source. Comes with a hard case. Good condition. Call David Simmons at:

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## Emergency Medicine Opportunities

Epectrum Emergency Care, the nation's largest provider of emergency department staffing and management services, currently has full and part-time staff physician opportunities at select client hospitals in Arkansas. As an independent contract physician, you will enjoy a variety of geographical locations in both large and small areas. Spectrum also offers participation in an occurrence-based malpractice insurance program, flexible scheduling, administrative support, and the opportunity for advancement. To learn more about the exciting opportunities currently available, call Dan Fuller at 800-325-3982, ext. 7809. Spectrum Emergency Care, 999 Executive Parkway, St. Louis, MO 63141.



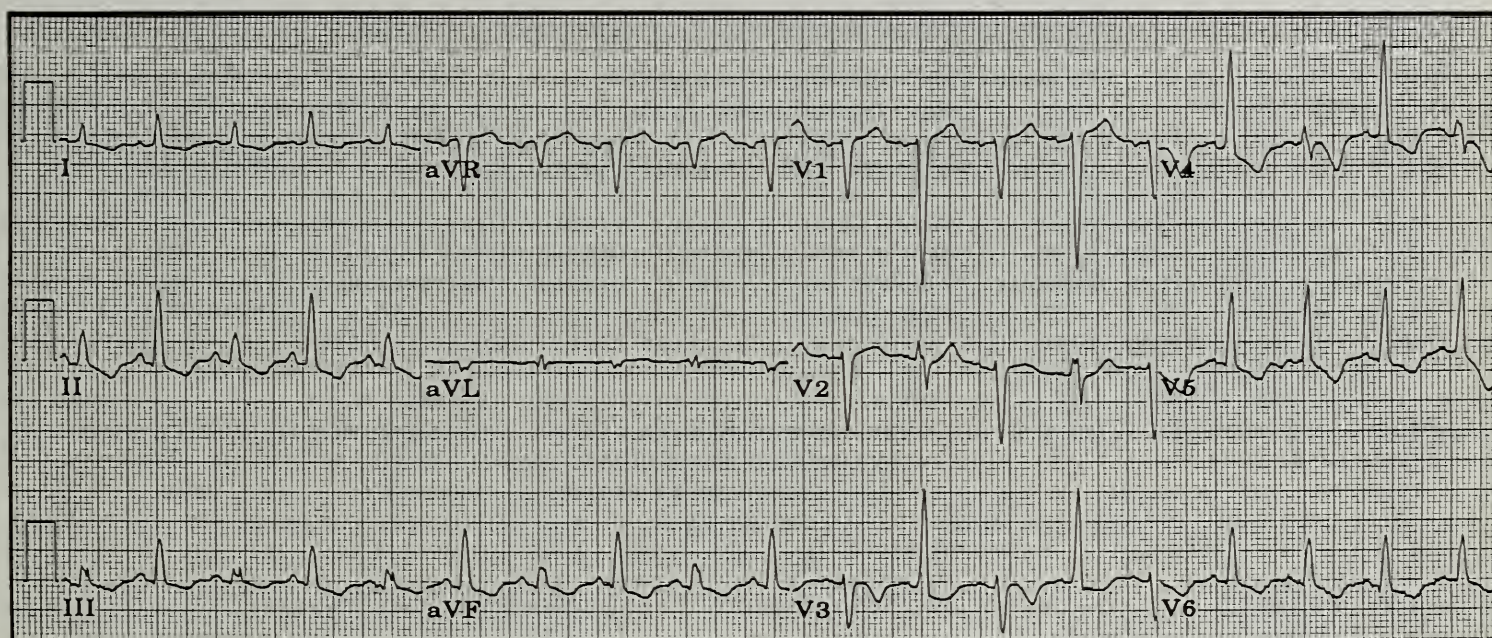


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## HISTORY:

This record was obtained from a 65-year-old male who presented to the Emergency Department complaining of cough, fever, and fatigue. He had a history of extensive surgery for head and neck carcinoma in the remote past. The physical exam revealed distended neck veins and a pulsus paradoxus of 40 mm Hg. A chest film revealed an enlarged cardiac silhouette.



## DISCUSSION:

Sinus tachycardia is present with a PR interval of 130 ms. The QRS axis and duration is normal. Non-specific ST and T wave abnormalities are present. The most striking abnormality of this record is the alternation of the QRS morphology. This is clearly evident in lead V3 where the QRS axis changes approximately 180 degrees in every other complex. There is a suggestion of P wave alternans as well. These electrocardiographic findings, particularly in the clinical setting provided are highly suggestive of a large pericardial effusion. Electrical alternans is suggestive of pericardial tamponade, with some authorities suggesting that P wave alternans is more specific for tamponade. Large pericardial effusions are generally associated with low QRS voltages. The QRS voltages in this record is normal, perhaps because the patient demonstrated left ventricular hypertrophy on electrocardiograms obtained after surgery.

Echocardiography revealed a massive pericardial effusion with a pendular motion of the heart in the fluid-filled pericardium, the so-called "swinging heart syndrome." It is felt that the swinging of the heart results in the alteration of the QRS morphology. Diastolic collapse of the right ventricle and right atrium supported the diagnosis of pericardial tamponade. At surgery, approximately 1.5 liters of fluid were removed. Pathologic examination of the pericardium revealed mild chronic inflammation.



# Things To Come

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## **March 13-15**

**19th Annual Scientific Meeting of the American College of Nuclear Medicine.** Sheraton New Orleans Hotel, LA. For more information, contact Thomas Johnson at (717) 898-6006.

## **March 27-28**

**Leukocyte Reduction and Blood Component Therapy.** Stouffer Concourse Hotel, Arlington, VA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$200, members; \$250, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

## **April 2-3**

**19th Annual Obstetrics & Gynecology Symposium.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## **April 22-26**

**Symposium on Management of Common Infections in Practice; 12th Annual National Pediatric Infectious Disease Seminar; and Special Session on Risk Management in the Pediatric Office.** Grand Hyatt Hotel, Washington, D.C. Sponsored by the Department of Pediatrics, Southwestern Medical School, The University of Texas Southwestern Medical Center. Fees: \$350; \$250, residents, fellow, PA's and PNP's. AMA Category I, AAFP, and PREP credits available. For more information, contact Marian Troup at (214) 688-8845.

## **April 22-26**

**6th Annual Critical Care Update.** Hyatt Regency-Capitol Hill, Washington, D.C. Co-sponsored by the Society of Critical Care Medicine, Rush Presbyterian-St. Luke's Medical Center, in cooperation with the Critical Care Medicine Department of the Clinical Center of the National Institutes of Health. Category I credits available. For more information, contact Svetlana Lisanti at (201) 385-8080.

## **April 24-25**

**5th Hearing Aid Conference.** The Clarion Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## **April 27- May 1**

**25th National Conference on Breast Cancer.** The Westin Hotel, Copley Place, Boston, Massachusetts. Sponsored by the American College of Radiology.

## **May 2-4**

**18th Annual Meeting of the Federated Ambulatory Surgery Association.** The Boston Marriott, Copley Place. For more information, call (703) 836-8808.

## **May 5**

**Surgery in the Developing World.** The Royal Society of Medicine, London, England. For more information, write to Keith Newton, The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE.

## **May 7-9**

**2nd Annual Cardiovascular Disease Review & Update.** Hotel Inter-Continental, Chicago, IL. Sponsored by the Rush Heart Institute, Section of Cardiology, Department of Cardiovascular and Thoracic Surgery, Rush Presbyterian - St. Luke's Medical Center. Category I credits offered. For more information, contact Svetlana Lisanti at (201) 385-8080.

## **May 15-16**

**Advanced Laparoscopy for the General Surgeon.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## **June 4-7**

**Advances in Aesthetic & Reconstructive Breast Surgery.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

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# Keeping Up

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## **Annual Cardiovascular Update**

February 28, 7:30 a.m. - 4:30 p.m., J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. Sponsored by the BMC Medical Affairs Department. Category I credits offered. Fees: \$115 for M.D., D.O., Ph.D., D.M.D., and P.D.; \$50 for nurses and other healthcare professionals; no charge for ACVI members, residents, and medical students. Registration must be received. For more information, call BMC Medical Affairs at (501) 227-2672.

## **Contemporary Trends in Pediatric Anesthesia**

February 29, 7:15 a.m. - 4:30 p.m., Excelsior Hotel/Statehouse Convention Center, Little Rock. Sponsored by the Arkansas Society of Anesthesiologists and the Department of Anesthesiology at the University of Arkansas for Medical Sciences. For more information, contact Barbara Pitts at (501) 686-6125.

## **8th Annual Arkansas Health Education Conference**

March 12-13, Excelsior Hotel/Statehouse Convention Center, Little Rock. Sponsored by the Arkansas Department of Health. For more information, contact Barbie Brunner at (501) 661-2207 or Misty Drake at (501) 624-1159.

## **Arkansas Hand Club Annual Meeting**

May 8-9, 1992, Gaston's White River Resort, Lakeview. For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

### **FAYETTEVILLE - VA MEDICAL CENTER**

Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Pathology classroom. Lunch provided  
Cancer Center Team Conference, 3rd Thursday, 12:00 noon. Lunch provided



*Sleep Disorders Case Conference*, every other Thursday, Video Production conference room. Lunch provided  
*Interdisciplinary AIDS Conference*, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served

## **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference*, 3rd Thursday, 7:00 a.m., conference room 1  
*GI Conference*, 4th Friday, 12:00 noon, conference room 1  
*Grand Rounds Conference*, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Pathology Conference*, 1st Tuesday, 3:00 p.m., Pathology Library  
*Pediatric Grand Rounds*, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor /BMC. Lunch provided.  
Category 1 credits available.  
*Pulmonary Conference*, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
*Sleep Case Conference*, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum*, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits  
*Anesthesia Lecture Series*, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Anesthesia Morbidity & Mortality Conference*, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B  
*Arkansas Blood & Cancer Society Conference*, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock  
*Cardiology Clinical Conference*, Mondays, 4:00 p.m., UAMS, room 3S06  
*Cardiology Graphics Conference*, Wednesdays, 12:00 noon, UAMS, room 3S06  
*CARTI North Tumor Board Cancer Conference*, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
*Cardiothoracic Surgery Conference*, date, time, & location varies  
*Cardiothoracic Surgery Monthly Journals Club*, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Cardiothoracic Surgery Morbidity & Mortality Conference*, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
*Child Psychiatry Update/Case Conference*, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
*CME Outreach Program*, dates, times & locations vary  
*Emergency Medicine Didactic Conference 1*, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Didactic Conference 2*, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
*Emergency Medicine Grand Rounds 1*, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
*Emergency Medicine Grand Rounds 2*, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
*Endocrinology Case Conference*, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
*Gastroenterology Grand Rounds*, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
*GI/Radiology Conference*, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
*Hematology/Oncology Fellow's Forum*, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
*Interhospital Urology Grand Rounds*, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
*LR Cancer Conference*, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
*LR Vascular Conference*, time & date varies monthly, rotates between UAMS, SVI & BMC  
*Medicine Grand Rounds*, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
*Med/Path Conference*, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
*Medicine Journal Club*, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
*Medicine Research Conference*, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
*Neurology Clinical Case Conference*, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
*Neuropathology Conference*, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
*Neuroradiology Conference*, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
*Neuroscience Conference (Basic)*, Mondays, 8:00 a.m., UAMS 7D33  
*Neuroscience Conference (Basic & Clinical)*, Wednesdays, 4:00 p.m., UAMS 7C  
*Neurosurgery Journal Club*, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
*Neurosurgical Pathology Conference*, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
*OB/GYN Fetal Boards*, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.  
*OB/GYN Grand Rounds*, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
*Ophthalmology Problem Case Conference*, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
*Ophthalmology Residency Morning Lectures*, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
*Orthopaedic Basic Science Conference*, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Bibliography Conference*, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours



*Orthopaedic Fracture Conference*, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
*Orthopaedic Grand Rounds*, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
*Pathology Autopsy Conference*, Wednesdays, 12:00 noon, VAMC-LR Morgue  
*Psychiatry Grand Rounds*, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
*Surgery Basic Sciences Conference*, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
*Surgery Grand Rounds*, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
*Surgery Morbidity & Mortality Conference*, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
*Surgery Resident Case Conference*, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## **FORT SMITH - AHEC**

*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville



*Interesting Case Conference*, 4th & 5th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Walnut Ridge CME Conference*, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
*White River CME Conference*, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

## **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

## **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

## **ARKANSAS**

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Arkansas Medical Society .....	429
Arkansas Medical Society .....	457
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Cheraw Family Medicine .....	462
Collom & Carney Clinic Association .....	435
Eli Lilly & Company .....	440
<i>Garrison, Jasper, Rose &amp; Company</i>	
Eli Lilly & Company .....	441
Tommy Farrell Associates .....	450
<i>Thomas J. Farrell Agency</i>	
Tommy Farrell Associates .....	457
I CARE of Arkansas .....	back cover
Medical Personnel Pool .....	432
MEDX.....	447
Mississippi Methodist Rehab Center .....	445
<i>Maris, West &amp; Baker, Inc.</i>	
Orthopaedics .....	440
<i>Comp-Art of Louisville, Inc.</i>	
PHP Healthcare .....	429
Radiology Consultants .....	436
Riverside Motors, Inc. ....	451
<i>Benson/Smith Advertising</i>	
State Volunteer Mutual Insurance Company .....	430
<i>The Maryland Group</i>	
U.S. Air Force .....	459
<i>Bozell, Inc.</i>	
U.S. Air Force Reserve .....	435
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All manuscripts should be submitted to Stephanie Percefull, Managing Editor, Arkansas Medical Society, P.O. Box 5776, Little Rock, Arkansas 72215. A transmittal letter should accompany the article and should identify one author as the correspondent and include his/her address and telephone number.

### MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" floppy diskette containing the manuscript. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

### REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the author(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

### ILLUSTRATIONS

Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 10

March 1992

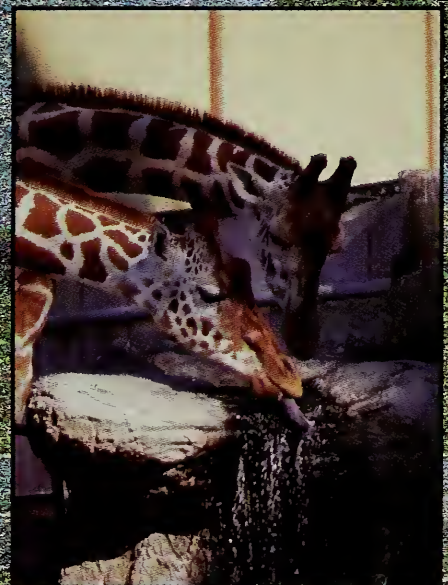
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## 116th Annual Session

Arkansas Medical Society  
Excelsior Hotel & Statehouse Convention Center  
Little Rock, Arkansas  
April 9 - 11, 1992



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At API, we pride ourselves on being professional. We dress like professionals dress, we have genteel manners, and we do what professionals do. But when claims are filed against our Members, we become, well ... you get the picture.

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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 10

March 1992

## CONTENTS

### FEATURES

478	116th AMS Annual Session Program
480	68th AMS Auxiliary Session Program
482	Featured Program Speakers
484	General Registration Information
485	Registration Form
486	Other Meetings
490	House of Delegates
492	Nominating Committee
496	Business Reports

### DEPARTMENTS

526	AMS Newsmakers
527	New Members
528	Medicine in the News
531	Radiological Case of the Month
534	Resolution
534	In Memoriam
535	Electrocardiogram of the Month
538	AIDS in Arkansas Statistics
540	Things to Come
543	Keeping Up

Cover photo by A.C. Haralson of the Arkansas Department of Parks & Tourism.



# Doctor's Day

*Thank You, Arkansas' Doctors!*



To show our appreciation for the medical care you've shown the people of Arkansas, the following hospitals and medical auxiliary members have contributed to the American Medical Association Education & Research Foundation, in celebration of Doctor's Day, March 30, 1992.

## **Facilities**

*The Medical Center of South Arkansas, El Dorado*  
*Ouachita County Hospital, Camden*  
*UAMS Medical Center*  
*Washington Regional Medical Center, Fayetteville*

## **Auxiliary Members**

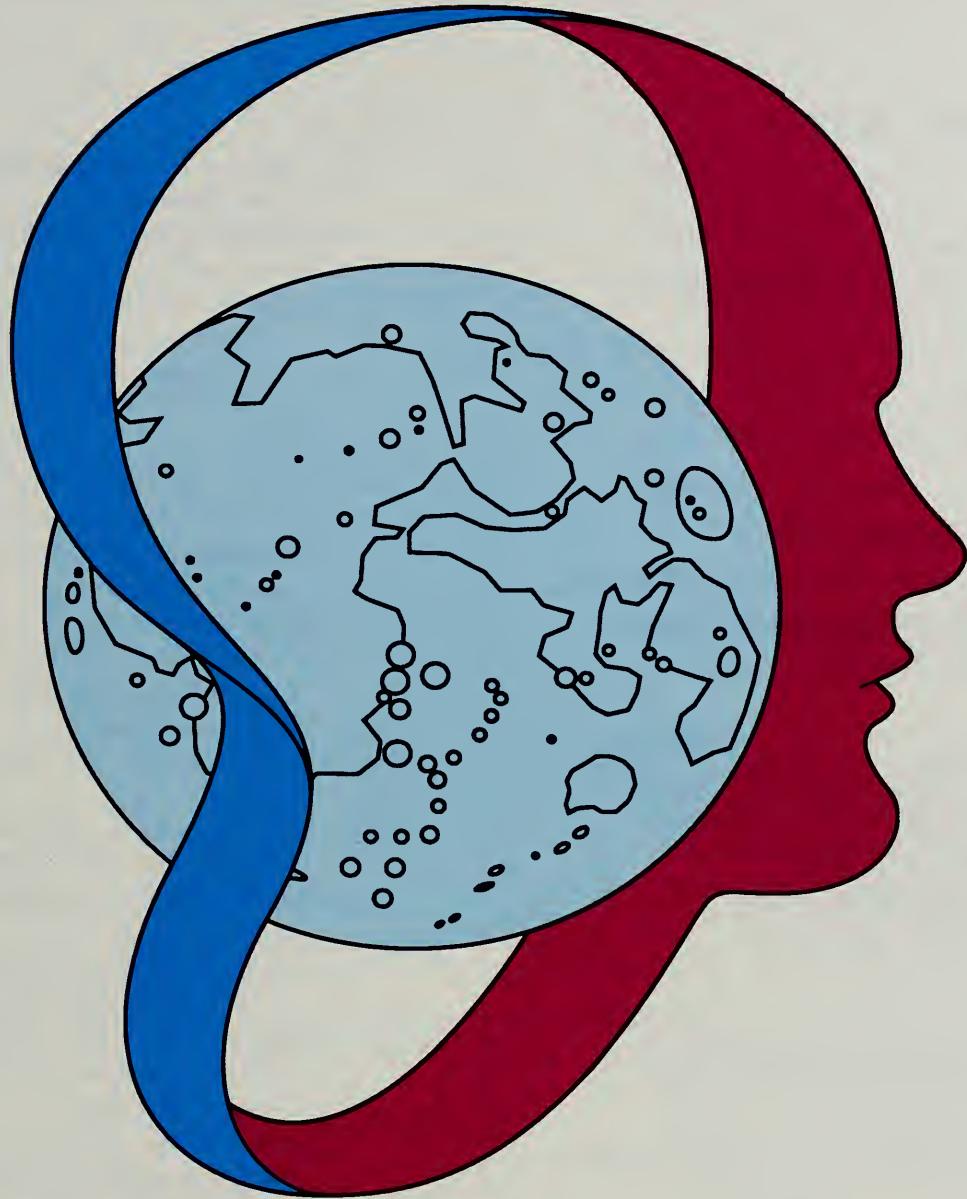
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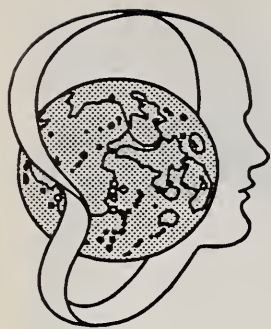


# The Changing World of Medicine



Arkansas Medical Society 116th Annual Session  
Excelsior Hotel - Statehouse Convention Center  
Little Rock, Arkansas  
April 9 - 11, 1992





# The Changing

## Arkansas Medical Society 116th Annual Session

**THURSDAY, APRIL 9, 1992**

1:00 p.m. - 5:00 p.m.

**Registration Open**

Osage Room - Statehouse Convention Center

3:00 p.m.

**Council Meeting**

River Valley Room - Excelsior Hotel

4:00 p.m.

**Early Arrival Hospitality Hour  
for Physicians, Spouses and Exhibitors**

Rotunda - Statehouse Convention Center

*Sponsored by Worthen Bank*

5:00 p.m.

**House of Delegates**

Salon B - Excelsior Hotel

*Joseph T. Painter, M.D.*

*Chairman, Board of Trustees*

*American Medical Association*

*Houston, Texas*

7:00 p.m.

**Blue Cross Blue Shield Reception  
for AMS Members and Spouses**

Salon C - Excelsior Hotel

AMA-ERF Fundraiser - Silent Basket Auction

**FRIDAY, APRIL 10, 1992**

7:30 a.m. - 5:00 p.m.

**Registration Open**

Osage Room - Statehouse Convention Center

8:00 a.m.

**Reference Committee Meetings**

River Valley/LaSalle/LaHarpe - Excelsior Hotel

8:30 a.m.

**Exhibit Center Open**

Governor's Hall II - Statehouse Convention Center

*Breakfast Sponsored by First Commercial Bank*

10:30 a.m.

**"Is There a Certified Rural Health Clinic  
in Your Future?"**

Governor's Hall I - Statehouse Convention Center

*Penny Washington, Reimbursement Specialist*

*North Carolina Office of Rural Health and*

*Resource Development*

*Durham, North Carolina*

12:00 noon

**Shuffield Lecture/Luncheon**

Salon C - Excelsior Hotel

*Recognition of Shuffield Award Winner*

**"An Agenda For Solving America's  
Health Care Crisis"**

*John C. Goodman, Ph.D., President*

*National Center for Policy Analysis*

*Dallas, Texas*

1:45 p.m.

**"Is The Grass Really Greener ....  
An International Perspective"**

Governor's Hall I - Statehouse Convention Center

*John Grasse Jr., M.D.*

*(formerly practiced in Republic of Zaire)*

*Calico Rock, Arkansas*

*Reginald J. Rutherford, M.D.*

*(formerly practiced in Canada)*

*Searcy, Arkansas*

*Joanna Thomas, M.D.*

*(formerly practiced in England)*

*Fayetteville, Arkansas*

3:00 p.m.

**Exhibit Center Open**

Governor's Hall II - Statehouse Convention Center

*"Around the World Sampler"*

*Sponsored by Continental Medical Systems*

3:15 p.m.

**Speaker & Reference Committee  
Chairmen Meeting**

Quapaw Room - Statehouse Convention Center

4:30 p.m.

**Council Meeting**

River Valley Room - Excelsior Hotel



# World of Medicine

**Excelsior Hotel ▫ Statehouse Convention Center  
Little Rock, Arkansas ▫ April 9 - 11, 1992**

7:00 p.m.

## **Mardi Gras Reception**

Salon C - Excelsior Hotel

*Sponsored by The Medical Protective Company*

## **SATURDAY, APRIL 11, 1992**

8:00 a.m. - 4:00 p.m.

## **Registration Open**

Osage Room - Statehouse Convention Center

8:30 a.m.

## **"RBRVS Panel Discussion"**

Salon B - Excelsior Hotel

*Representatives from different specialties will review RBRVS and the effect on physicians' practices after implementation.*

10:00 a.m.

## **Exhibit Center Open**

Governor's Hall II - Statehouse Convention Center

**Grand Prize Drawing for AMS Members:** Two round trip airline tickets to anywhere in the Continental United States. Donated by Tours & Travel of Russellville.

**Exhibitor Grand Prize Drawing:** \$200. Donated by the Arkansas Medical Society.

*Brunch Sponsored by AMS Benefits, Inc.*

12:00 noon

## **Fifty Year Club Luncheon**

River Valley Room - Excelsior Hotel

*Honors physicians who have practiced medicine for over 50 years.*

12:30 p.m.

## **Specialty Meetings**

Arkansas Academy of Family Physicians

Arkansas Chapter, American College of Radiology

Arkansas Orthopaedic Society

Arkansas Pathology Society

Arkansas Psychiatric Society

Arkansas Society of Plastic & Reconstructive Surgeons

Arkansas Urologic Society

1:00 p.m.

## **AIDS Seminar**

Salon B - Excelsior Hotel

### **"HIV Management"**

*Brady Allen, M.D.*

*Associate Clinical Professor*

*Baylor University Medical Center*

*Dallas, Texas*

3:30 p.m.

## **Memorial Service**

Salon C - Excelsior Hotel

4:00 p.m.

## **House of Delegates**

Salon B - Excelsior Hotel

7:00 p.m.

## **Inaugural Banquet**

Salon C - Excelsior Hotel

### **"Can't Stop the Music"**

*A Vocal Musical Showcase*

*Entertainment Sponsored by State Volunteer*

*Mutual Insurance Company*

9:00 p.m.

## **New President's Reception**

Balcony - Excelsior Hotel

*Honors incoming 1992-93 AMS President.*

*Sponsored by American Physicians Insurance Exchange*

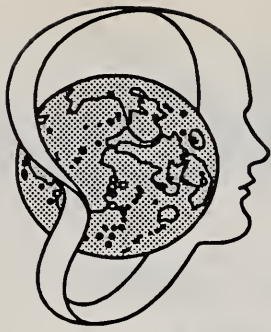
### **Message from the Chairman:**

*As Chairman of the Annual Session Committee, I urge you to attend the 116th Annual Session of the Arkansas Medical Society.*

*The scheduled programs are excellent and should be of interest to you. The world of medicine is changing daily, and we as physicians need to stay informed.*

*Glen F. Baker, M.D.*





# Toward the Year 2000:

## Arkansas Medical Society Auxiliary 68th Annual Session

**THURSDAY, APRIL 9, 1992**

1:00 p.m. - 5:00 p.m.

### **Registration**

Caddo Room - Statehouse Convention Center

.....

10:00 a.m. - 2:30 p.m.

### **Arkansas Leadership Confluence**

Pope Room - Statehouse Convention Center

Mrs. Sandy Harrison, Presiding

*For all 1992-93 State and County officers and  
chairpersons*

12:00 p.m.

### **Confluence Luncheon**

River Valley Room - Excelsior Hotel

*Speaker: Mrs. Willie Oates*

.....

3:00 p.m.

### **Pre-Convention Board Meeting**

Pope Room - Statehouse Convention Center

Mrs. Rita Rodgers, Presiding

1991-1992 Board

4:00 p.m.

### **Early Arrival Hospitality Hour for Physicians, Spouses and Exhibitors**

Rotunda - Statehouse Convention Center

*Sponsored by Worthen Bank*

7:00 p.m.

### **Blue Cross Blue Shield Reception**

Salon C - Excelsior Hotel

AMA-ERF Fundraiser-Silent Basket Auction

Mrs. Sandy Finkbeiner, Chairperson

**FRIDAY, APRIL 10, 1992**

7:30 a.m. - 4:30 p.m.

### **Registration**

Caddo Room - Statehouse Convention Center

8:00 a.m.

### **Continental Breakfast**

Pope Room - Statehouse Convention Center

8:30 a.m.

### **"Healthier Youth by the Year 2000: Adolescent Pregnancy"**

Pope Room - Statehouse Convention Center

*Speaker: Karen Kozlowski, M.D.*

*Assistant Professor of OB/GYN and*

*Pediatrics - UAMS*

*Director of Pediatric Adolescent*

*OB/GYN - ACH*

*Little Rock, Arkansas*

9:30 a.m.

### **Opening General Session**

Pope Room - Statehouse Convention Center

Mrs. Rita Rodgers, President, Presiding

### **General Business, Roll Call, and Seating of Delegates**

#### **Introduction of Special Guests:**

Mrs. Sancy McCool, AMA-ERF Chairman  
American Medical Association Auxiliary

Mrs. Ebba Dunn, President-elect

Southern Medical Association Auxiliary

Joseph T. Painter, M.D., Chairman

Board of Trustees

American Medical Association

George Warren, M.D., President

Arkansas Medical Society

Mr. Ken LaMastus, Executive Vice President

Arkansas Medical Society

Ms. Kay Waldo, Director of Administrative  
Services

Arkansas Medical Society

#### **Address:**

Mrs. Sancy McCool

#### **Convention Announcements:**

Mrs. Debbie Velez, Convention Chairman

#### **Reports of Officers and Committee Chairmen**

#### **Unfinished Business**

#### **New Business**

Election of the Nominating Committee for  
1992-1993

(2 from the Board; 2 from the House of  
Delegates)

Election of Delegates and Alternates to the  
1992 AMA Auxiliary Convention, Chicago

Presentation of the 1992-1993 Budget:

Mrs. Sara Jouett, Finance Chairman

#### **Adjournment**



# A New Decade, A New Resolve

Excelsior Hotel □ Statehouse Convention Center  
Little Rock, Arkansas □ April 9- 11, 1992

12:00 noon

## **Shuffield Lecture and Luncheon**

Salon C - Excelsior Hotel

Recognition of Award Winner

### **"An Agenda for Solving America's Health Care Crisis"**

*Speaker: John C. Goodman, Ph.D., President  
National Center for Policy Analysis  
Dallas, Texas*

2:00 p.m.

## **"Empowering the Family"**

Pope Room - Statehouse Convention Center

*Speaker: Gail S. Harber, MS, NCAC II, CCDC III  
Roland, Arkansas*

*Moderator: Mrs. JoAnn Browning, Chairman  
AMSA Support Committee*

*A discussion of change within the family. A panel  
of spouses will share their personal experiences.*

7:00 p.m.

## **Mardi Gras Reception**

Salon C - Excelsior Hotel

*Sponsored by The Medical Protective Company*

## **SATURDAY, APRIL 11, 1992**

8:00 a.m. - 12:00 noon

## **Registration**

Caddo Room - Statehouse Convention Center

8:00 a.m.

## **Past Presidents' Breakfast**

Baxter Room - Capitol Hotel

*Chairmen: Mrs. Mary Jo Mizell  
Mrs. Mary Gardner*

8:15 a.m.

## **Continental Breakfast**

Pope Room - Statehouse Convention Center

8:45 a.m.

## **"Toward the Year 2000: Medicine's Future, Planning for Change"**

*Speaker: Brian A. Baker, Executive Director  
Family Clinic, Ltd.*

*Officer/Member, Medical Group Management  
Association  
Little Rock, Arkansas*

9:30 a.m.

## **Second General Session**

Pope Room - Statehouse Convention Center

*Mrs. Rita Rodgers, President, Presiding*

### **General Business**

### **Greetings from Southern:**

*Mrs. Ebba Dunn*

### **Reports by County Presidents:**

*Moderators: District Vice Presidents*

### **Unfinished Business**

### **New Business**

*1991-92 Nominating Committee Report:*

*Mrs. JoAnn Williams*

*Election of Officers*

### **Adjournment**

12:15 p.m.

## **AMSA Installation Luncheon**

Josephine's - Excelsior Hotel

*Hostess: Pulaski County*

*Presiding: Mrs. Rita Rodgers, President*

### **Presentation of Awards**

### **Installation of Officers:**

*Mrs. Sancy McCool*

2:30 p.m.

## **Post Convention Board Meeting**

Pope Room - Statehouse Convention Center

*Mrs. Sandy Harrison, Presiding*

*1992-1993 Board*

3:30 p.m.

## **Memorial Service**

Salon C - Excelsior Hotel

7:00 p.m.

## **AMS Inaugural Banquet**

Salon C - Excelsior Hotel

*"Can't Stop the Music"*

*A Vocal Musical Showcase*

*Entertainment Sponsored by State Volunteer*

*Mutual Insurance Company*

9:00 p.m.

## **AMS President's Reception**

Balcony - Excelsior Hotel

*Sponsored by American Physicians Insurance  
Exchange*





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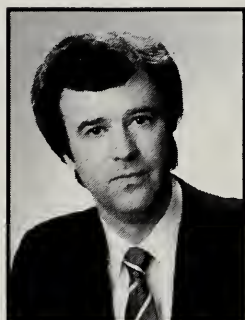
Arkansas Medical Society  
116th Annual Session  
and the  
Arkansas Medical Society Auxiliary  
68th Annual Session



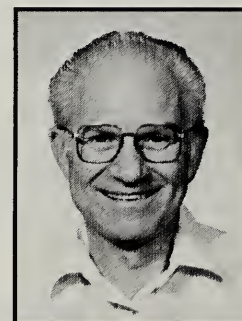
*Joseph T. Painter, M.D.  
Chairman  
Board of Trustees  
American Medical Association  
Houston, Texas*



*Penny Washington  
Reimbursement Specialist  
North Carolina Office of Rural Health  
and Resource Development  
Durham, North Carolina*



*John C. Goodman, Ph.D.  
President  
National Center for Policy Analysis  
Dallas, Texas*



*John Grasse Jr., M.D.  
Family Practice  
Medical Center Clinic  
Calico Rock, Arkansas  
(formerly practiced in Republic of Zaire)*

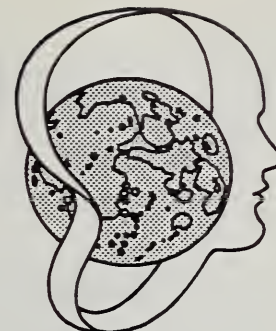


*Reginald J. Rutherford, M.D.  
Neurology  
Searcy Medical Center  
Searcy, Arkansas  
(formerly practiced in Canada)*



# Speakers

April 9 - 11, 1992  
Excelsior Hotel  
and the  
Statehouse Convention Center  
Little Rock, Arkansas



*Joanna Thomas, M.D.  
Family Practice  
AHEC-NW  
Fayetteville, Arkansas  
(formerly practiced in England)*



*Karen Kozlowski, M.D.  
Assistant Professor, OB/GYN and Pediatrics  
University of Arkansas for Medical Sciences  
Director, Pediatric Adolescent OB/GYN  
Arkansas Children's Hospital  
Little Rock, Arkansas*



*Mrs. Sancy McCool  
AMA-ERF Chairman  
American Medical Association Auxiliary  
Baton Rouge, Louisiana*



*Mrs. Ebba Dunn  
President-elect  
Southern Medical Association Auxiliary  
Wetumpka, Alabama*



*Gail S. Harber, MS, NCAC II, CCDC III  
Coordinator of Addiction Studies  
Department of Pediatrics  
University of Arkansas for Medical Sciences  
Director of Education  
Arkansas Children's Hospital  
Little Rock, Arkansas*





# General Information

## Registration and Fees

The convention registration desk will be located in the Statehouse Convention Center and will be staffed during the following times:

Thursday, April 9	1:00 p.m. - 5:00 p.m.
Friday, April 10	7:30 a.m. - 4:30 p.m.
Saturday, April 11	8:00 a.m. - 4:00 p.m.

No person will be admitted to any activity of the Annual Session without first registering. Upon checking in at the convention registration desk, you will receive a convention program, your name badge, tickets for meals and social functions, and other convention material.

	Pre-registration	On-site Registration
Member	\$75.00	\$90.00
Non-member	\$110.00	\$125.00
Spouse	\$55.00	\$70.00

AMS Past Presidents receive a \$25.00 discount. There is no charge for Students and Residents.

## Telephone Service

The Society will have a convention telephone at the registration desk during registration hours for your convenience. Call the Statehouse Convention Center at (501) 376-4781, extension 1024. You may leave this number with your office personnel in case of emergencies.

## Hotel Reservation Information

Call the Excelsior Hotel at 1-800-334-6680 by March 8th to receive the AMS room rate. Be sure to tell them that you are with the Arkansas Medical Society meeting to be held April 9-11, 1992.

## Cancellation Policy

All cancellations must be made in writing and received by March 31st to receive a refund. No refunds will be given after that date. All refunds, minus a \$10 processing fee, will be mailed after the conference. No refunds will be given on site.

## Exhibits

Commercial exhibits will be on display in Governor's Hall II in the Statehouse Convention Center. They will be open during the following times:

Friday, April 10:	8:30 a.m. - 10:30 a.m.
	3:00 p.m. - 4:45 p.m.
Saturday, April 11:	10:00 a.m. - 12:15 p.m.

Dr. Glen Baker, Annual Session chairman, urges all members and their guests to take the time to visit the displays. The exhibits are a part of the educational program of the convention and provide members with the latest information on progress in pharmaceutical research, developments in instruments and equipment, insurance, accounting systems, computers, investments, and other new products and services available. The exhibits represent an important contribution to the convention. You are urged to visit each booth and let the exhibitors know you appreciate their participation.

## Continuing Medical Education Credit

The Arkansas Medical Society is an accrediting sponsor of continuing medical education. This program is approved for 7.25 hours of hour-for-hour credit in Category I of the Physician's Recognition Award of the American Medical Association. This program is also being reviewed for prescribed credit hours by the American Academy of Family Physicians.

## Convention Officials

### *Chairman*

Glen F. Baker, M.D., Little Rock

### *AMS President*

George Warren, M.D., Smackover

### *AMS President-elect*

J. Larry Lawson, M.D., Paragould,

### *AMS Auxiliary Convention Chairman*

Mrs. Debbie Velez, Little Rock

### *AMS Auxiliary Convention Co-chairman*

Mrs. Melissa Casper, Little Rock



# Convention Registration Form



Dr. \_\_\_\_\_  
(Please Print)

Mr./Mrs. \_\_\_\_\_  
(First and Last Name)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

## Adopt-a-Doctor Discount

Take \$25.00 off your registration fee if you bring a physician who has never attended (or if you have never attended) an AMS Annual Session. Your "Adopted Doctor" is:

\_\_\_\_\_ of \_\_\_\_\_  
(Name) (City)

## Registration Information

AMS Member and Spouse fees cover the Shuffield Luncheon, Inaugural Banquet, Exhibit Center Continental Breakfast, Exhibit Center Brunch, and entrance into the Exhibit Center.

No one will be allowed in the Exhibit Center without a registration badge.

### Registration Fees:

	Pre-Paid	On-Site
Member	\$75.00	\$90.00
Non-Member	\$110.00	\$125.00
Spouse	\$55.00	\$70.00
Auxiliary Luncheon	\$20.00	\$25.00

For appropriate meal count, please indicate number attending:

\_\_\_\_\_ # Attending Shuffield Luncheon  
\_\_\_\_\_ # Attending Inaugural Banquet  
\_\_\_\_\_ # Attending Auxiliary Luncheon

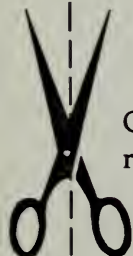
AMS Past Presidents receive \$25.00 discount.  
Students/Residents - No Charge with proper ID

Cancellations must be made in writing and received by March 31st to receive a refund. All refunds, minus a \$10.00 processing fee, will be mailed after the session.

Total Amount Enclosed \$ \_\_\_\_\_

Checks for member, spouse, and auxiliary registration should be made payable to and forwarded with the registration form to:

Arkansas Medical Society  
P.O. Box 5776  
Little Rock, AR 72215-5776





# Other Meetings

## **Fifty Year Club Luncheon**

The Society will host a luncheon for members of the Fifty Year Club at 12:00 noon, Saturday, April 11th, at the Excelsior Hotel. The Fifty Year Club President is Henry V. Kirby, M.D., of Harrison. Physicians eligible for the Fifty Year Club this year are: Francis R. Buchanan, M.D., Little Rock; John D. Christian, M.D., Little Rock; John W. Dodson Jr., M.D., Hot Springs; Buford M. Gardner, M.D., Fayetteville; Bland Harper, M.D., Monette; Evans Z. Hornberger Jr., M.D., Fort Smith; W. Duane Jones, M.D., Fort Smith; Albin J. Krygier, M.D., Horseshoe Bend; Joseph W. Ledbetter, M.D., Jonesboro; Art B. Martin, M.D., Fort Smith; Max J. Mobley, M.D., Russellville; Joseph A. Norton, M.D., Little Rock; Norman W. Peacock Jr., M.D., Ashdown; William G. Reese, M.D., Little Rock; Robert W. Ross, M.D., Clinton; Robert L. Salb, M.D., Crossett; Peter O. Thomas, M.D., Little Rock; Vernon L. Toombs, M.D., Gurdon; and Jacob M. Williams, M.D., Paragould.

## **Specialty Meetings**

**Arkansas Academy of Family Physicians** will meet Saturday, April 11th from 12:00 noon - 1:30 p.m. in the Fulton Room at the Statehouse Convention Center. C. Winston Brown, M.D., and Bobby Cogburn, M.D., will speak on "Quality of Life Issues in Cancer Patients."

**Arkansas Chapter, American College of Radiology** will meet Saturday, April 11th. The Board will meet in the Caraway III Room at the Statehouse Convention Center at 1:00 p.m., followed by a business meeting at 2:00 p.m.

**Arkansas Orthopaedic Society** will meet Saturday, April 11th in the LaHarpe Room at the Excelsior Hotel at 12:30 p.m.

**Arkansas Pathology Society** will meet Saturday, April 11th in the Caraway II Room at the Statehouse Convention Center from 1:00 p.m. - 3:00 p.m.

**Arkansas Society of Plastic and Reconstructive Surgeons** will meet Saturday, April 11th, from 12:30 p.m. - 1:30 p.m. in the Quapaw Room at the Statehouse Convention Center.

**Arkansas Psychiatric Society** will meet Saturday, April 11th in the Izard Room at the Statehouse Convention Center from 12:30 p.m. - 2:00 p.m.

**Arkansas Urologic Society** will meet Saturday, April 11th in the LaSalle Room of the Excelsior Hotel from 12:30 p.m. - 3:00 p.m. Mike Sarosdy, M.D., Professor and Chairman of the Urology Department, University of Texas Health Sciences Center, San Antonio, Texas, will be the speaker.

## **Memorial Service**

Members of the Arkansas Medical Society and Auxiliary who have died during this past year will be remembered during the Memorial Service at 3:30 p.m., at the Excelsior Hotel on Saturday, April 11th. Members to be honored are:

### *Society Members*

John W. Ashby, Benton  
Robert H. Atkinson, Hot Springs  
Charles C. Ault, North Little Rock  
James W. Branch, Hope  
Joe W. Chamberlain, Hot Springs  
Thomas F. Dilday, Little Rock  
R. Kirk Drange, Rogers  
Thomas M. Durham, Hot Springs  
James H. Fraser, Little Rock  
Edwin F. Gray, Little Rock  
Ralph B. Hamilton, West Memphis  
L. Gordon Holt, Little Rock  
Harry Jack "Hank" Jordan Jr., Jonesboro  
Ray W. Leavelle, Texarkana, Texas  
Vincent Lesh, Fayetteville  
George E. Mitchell, Fort Myers, Florida  
Doane M. Newton, Hot Springs  
V. Earl Parsons, Arkadelphia  
Malcolm O. Peeler, Jonesboro  
Bascom P. Raney, Jonesboro  
Robert L. Sherman, Fort Smith

### *Auxiliary Members and Spouses*

Mrs. James R. Fall (Mildred), West Memphis  
Mrs. Charles E. Garratt (Lucille), Hot Springs  
Mrs. Ellery C. Gay Sr. (Allie), Little Rock  
Mrs. Edwin F. Gray (Ruth), Little Rock  
Mrs. Walter P. Harris (Louise), Danville  
Mrs. F. Paul Hogue (Alice), Benton  
Mrs. William E. Knight (Mary), Fort Smith  
Mrs. Randolph Murphy (Carmen), Little Rock  
Mrs. C. Fletcher Watson (Ruth), Little Rock  
Mrs. J. Earle White (Gloria), Fort Smith



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Robert L. Moon



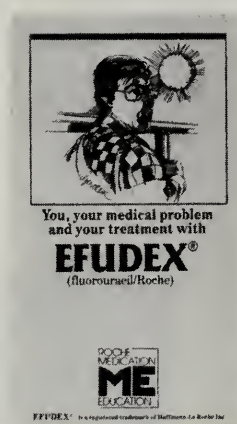
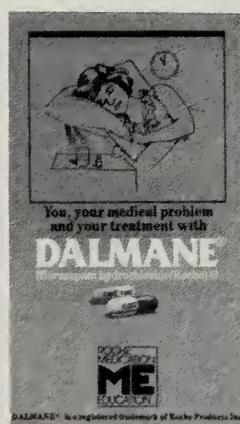
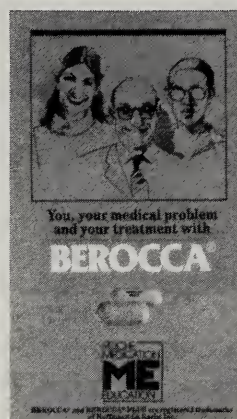
John D. Sagely, Jr.



# COMMITTED TO TOTAL HEALTH CARE

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presents the  
Resource Library  
for patient  
information*

## ROCHE ME MEDICATION EDUCATION

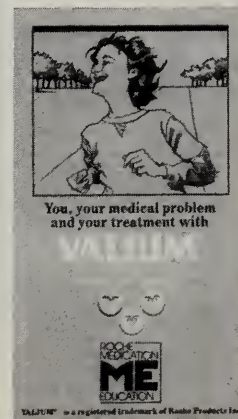
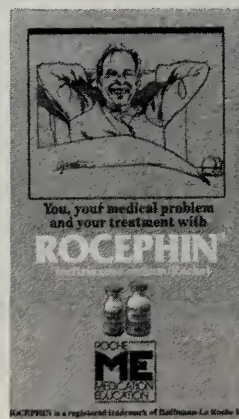
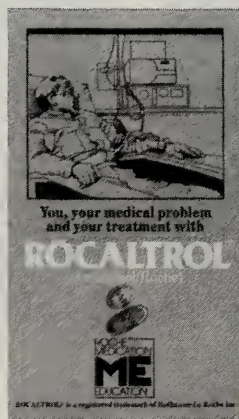
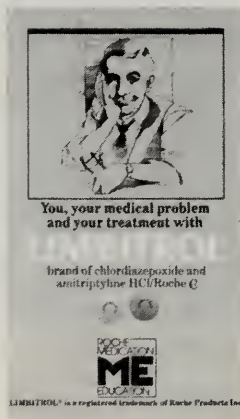
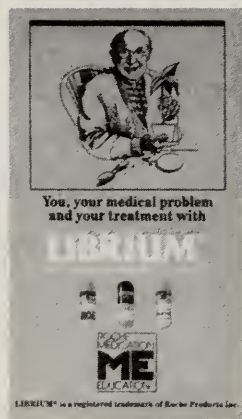


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- Enhancement of compliance
- Satisfaction with office visits

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"Family Resorts Of The Year Award" for 1990.





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# House of Delegates

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The opening session of the House of Delegates of the Arkansas Medical Society will begin at 5:00 p.m. on Thursday, April 9th. Speaker of the House John Crenshaw, M.D., will preside, assisted by Vice Speaker Kelsy J. Caplinger III, M.D.

All items of business to be considered by the House must either be printed in the convention issue of *The Journal* or submitted to the headquarters office in writing 20 days prior to the meeting. Any new business proposed during the session of the House of Delegates must have a two-thirds vote of attending delegates for introduction.

Items of business will be referred by the Speaker of the House of Delegates to one of two reference committees. Open hearings on those items of business will be held by the reference committees on Friday, April 10th at 8:00 a.m. All members of the Society are welcome to attend the meetings of the reference committees and to express views on the various reports, resolutions, etc.

The following will be seated at the House of Delegates during the 1992 Annual Session:

## Officers

John Crenshaw, Pine Bluff, speaker, (ex-officio)  
Kelsy J. Caplinger III, Little Rock, vice speaker, (ex-officio)  
George Warren, Smackover, president (ex-officio)  
J. Larry Lawson, Paragould, president-elect (ex-officio)  
Michael N. Moody, Salem, first vice president (ex-officio)  
Charles H. Rodgers, Little Rock, secretary (ex-officio)  
James M. Kolb Jr., Russellville, treasurer (ex-officio)

## Councilors

District 1: Dwight Williams, Paragould  
Merrill J. Osborne, Blytheville  
District 2: John E. Bell, Searcy  
Lloyd Bess, Batesville  
District 3: L. J. P. Bell, Helena  
Hoy B. Speer Jr., Stuttgart  
District 4: Paul A. Wallick, Monticello  
Lloyd G. Langston, Pine Bluff  
District 5: Robert Nunnally, Camden  
Wayne G. Elliott, El Dorado  
District 6: James D. Armstrong, Ashdown  
F. E. Joyce, Texarkana  
District 7: Ronald J. Bracken, Hot Springs  
Thomas H. Hollis, Hot Springs  
District 8: Glen F. Baker, Little Rock  
David L. Barclay, Little Rock  
Paul Cornell, Little Rock  
Charles Logan, Little Rock  
R. Jerry Mann, Little Rock  
Harold Purdy, Little Rock  
Robert Shannon, Little Rock

District 9: Robert H. Langston, Harrison  
David L. Rogers, Fayetteville  
District 10: Morton C. Wilson, Fort Smith  
Gerald A. Stolz, Russellville  
Paul Wills, Fort Smith

## Past Presidents (ex-officio)

Charles R. Henry Sr., Little Rock  
Joe Verser, Harrisburg  
C. Randolph Ellis, Malvern  
Joseph A. Norton, Little Rock  
H. W. Thomas, Dermott  
Ross E. Fowler, Harrison  
C. Stanley Applegate Jr., Springdale  
C. Robert Watson, Little Rock  
John P. Wood, Mena  
Ben N. Saltzman, Little Rock  
T.E. Townsend, Pine Bluff  
Albert S. Koenig Jr., Fort Smith  
W. Payton Kolb, Little Rock  
George F. Wynne, Warren  
A.E. Andrews Jr., Texarkana  
Kemal E. Kutait, Fort Smith  
Purcell Smith Jr., Little Rock  
Morriss M. Henry, Fayetteville  
Asa A. Crow, Paragould  
Charles F. Wilkins Jr., Russellville  
John P. Burge, Lake Village  
C.C. Long, Fort Smith (honorary)  
Ken Lilly, Fort Smith  
W. Ray Jouett, Little Rock  
John M. Hestir, DeWitt  
James R. Weber, Jacksonville  
William N. Jones, Little Rock



## Delegates for 1992 (as submitted by county)

	<u>Delegate</u>	<u>Alternate Delegate</u>
Arkansas (1)		
Ashley (1)	D. L. Toon	C. E. Ripley
Baxter (2)		
Benton (3)	William T. Summerlin Larry D. Wright	
Boone (1)	Carlton Chambers	John T. Troupe
Bradley (1)	Joe H. Wharton	Kerry F. Pennington
Carroll (1)		
Chicot (1)		
Clark (1)	Noland H. Hagood	James L. Lowry
Cleburne (1)	J. Warren Murry	James C. Lambert
Columbia (1)	H. Scott McMahan	John E. Alexander
Conway (1)		
Craighead/ Poinsett (6)	M. Lowery Beck Jerry D. Blaylock Joe H. Stallings Jr. Don B. Vollman Jr.	
Crawford (1)	Millard C. Edds	Lester R. Darden
Crittenden (1)	Steve P. Schoettle	E. Scott Ferguson
Cross (1)		
Dallas (1)	Don G. Howard	Hugh A. Nutt
Desha (1)		
Drew (1)		
Faulkner (1)	Jimmie J. Magie	Robert Rook
Franklin (1)		
Garland (5)		
Grant (1)		
Greene/ Clay (1)	Roger E. Cagle	William H. Rollins
Hempstead (1)	Richard P. Portis	Lowell O. Harris
Hot Spring (1)		
Howard/ Pike (1)		
Independence (2)	Lloyd G. Bess John R. Baker	William J. Waldrip
Jackson (1)		
Jefferson (4)	Simmie Armstrong Lee A. Forestiere David C. Jacks Anna T. Ridling	
Johnson (1)	Donald H. Pennington	Richard E. McKelvey
Lafayette (1)	Sanford E. Hutson	
Lawrence (1)	Ralph F. Joseph	Sebastian A. Spades
Lee (1)		
Little River (1)	Joe G. Shelton	
Logan (1)	John R. Williams	Guy Ulrich
Lonoke (1)	Leslie F. Anderson	Jerry C. Chapman
Miller (3)	John A. Gillean Joseph R. Robbins Herbert B. Wren	
Mississippi (1)	Joseph V. Jones	Joseph B. Rhodes
Monroe (1)	Neylon C. David	Linda F. Collins
Nevada (1)	Charles Vermont	
Ouachita (1)	William D. Dedman	Cal R. Sanders
Phillips (1)	L. J. P. Bell	Robert D. Miller
Polk (1)	M. Bryan Page	David D. Fried
Pope (2)	Kelly Meyer H. Kevin Beavers	

	<u>Delegate</u>	<u>Alternate Delegate</u>
Pulaski (32)	D. B. Allen Joseph M. Beck Ray V. Biondo Amail Chudy Bob E. Cogburn Gilbert O. Dean Jim English Charles P. Fitzgerald William E. Golden James L. Hagler Edwin Hankins III Fred O. Henker D. Andrew Henry C. Reid Henry Anthony D. Johnson Carl L. Johnson Marvin Leibovich Fred G. Nagel George A. Norton Walter H. O'Neal J. Mayne Parker Ashley S. Ross Edward H. Saer Bruce E. Schratz Frank M. Sipes William L. Steele Carl J. Raque John F. Redman Robert G. Valentine Jr. John L. Wilson Paul W. Zelnick	James R. Adametz John W. Baker John P. Brizzolara J. Roger Clark Lisa A. Cosgrove Brian D. Curtner Claudia M. Davis Phillip J. Deer III Cynthia N. Frazier David L. Gilliam A. David Hall H. Graves Hearnberger William F. Hefley Jr. J. Timothy Hodges Jerry C. Holton Harold G. Hutson G. Thomas Jansen John C. Jones Stephen K. Magie Michael C. Roberson Johnny K. Smelz Samuel B. Welch Virgil D. Wooten
Randolph (1)		
Saline (1)	Marvin N. Kirk	Frank G. Thibault
Sebastian (9)	R. Cole Goodman David B. Kocher A. Samuel Koenig III McDonald Poe John R. Swicegood John H. Wikman Carl L. Williams	Jimmie G. Atkins Randy Ennen David W. Hunton John L. Lange Steve B. Nelson Andre J. Nolewajka John J. Wells
Sevier (1)		
St. Francis (1)	Samuel A. McGuire	
Tri-County (1)	George W. Jackson	Donald O. Wright
Union (2)	Allan S. Pirniquie Robert C. Tommey	Gary L. Beville Bert Dougherty
Van Buren (1)	John A. Hall	Charles G. Pearce
Washington (6)		
White (2)		
Woodruff (1)	James E. Rowe	
Yell (1)	James L. Maupin	
Medical		
Student (1)	Janet Hodge	Yvette Randle
Resident (1)		

*Ex-officio members shall have the power of voting on all subjects except the election of officers.*



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## First Meeting, House of Delegates

5:00 p.m., Thursday, April 9th

John Crenshaw, M.D., Speaker

Kelsy J. Caplinger III, M.D., Vice Speaker

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## Final Meeting, House of Delegates

4:00 p.m., Saturday, April 11th

John Crenshaw, M.D., Speaker

Kelsy J. Caplinger III, M.D., Vice Speaker

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1. Call to order
  2. Presentation of the Colors
  3. Welcome to Little Rock
  4. Introduction of guests:
    - Mrs. Sancy McCool, 1991-92 Chairman  
AMA-ERF Committee  
American Medical Association Auxiliary
    - Mrs. Ebba Dunn, President-elect  
Southern Medical Association Auxiliary
    - Mrs. Rita Rodgers, President  
Arkansas Medical Society Auxiliary, Little Rock
    - Mrs. Sandy Harrison, President-elect  
Arkansas Medical Society Auxiliary, Little Rock
  5. Address by Joseph T. Painter, M.D.  
Chairman, Board of Trustees,  
American Medical Association, Houston, TX
  6. Adoption of minutes of the 115th Annual Session  
as published in the June 1991 issue of *The Journal of the Arkansas Medical Society*.
  7. Presentations
  8. Old Business
  9. New Business
    - All reports, resolutions, and other items of  
business received by the headquarters office 20  
days prior to the meeting shall be included in  
the agenda. Any items of business received  
after April 5th, must have two-thirds consent  
of attending delegates before introduction. All  
items will be referred to reference committees.
  10. Announcement of vacancies on State Boards:
    - Arkansas State Medical Board (Fourth Congress-  
sional District)
    - Arkansas State Board of Health (First and Fifth  
Congressional District)
  11. Recess until Saturday
1. Call to order
  2. Election of officers. Nominations as submitted  
by the Nominating Committee:
    - President-elect:  
Glen F. Baker, M.D., Little Rock
    - Vice President:  
Steve Schoettle, M.D., West Memphis
    - Treasurer:  
Lloyd G. Langston, M.D., Pine Bluff
    - Secretary:  
Charles H. Rodgers, M.D., Little Rock
    - Speaker of the House:  
John Crenshaw, M.D., Pine Bluff
    - Vice Speaker of the House:  
Kelsy J. Caplinger, III, M.D., Little Rock
    - Councilors:
      - District #1:  
Dwight Williams, M.D., Paragould
      - District #2:  
Michael N. Moody, M.D., Salem
      - District #3:  
Samuel A. McGuire, III, M.D., Forrest City
      - District #4:  
Paul A. Wallick, Monticello
      - District #5:  
Robert H. Nunnally, M.D., Camden
      - District #6:  
James D. Armstrong, M.D., Ashdown
      - District #7:  
Ronald J. Bracken, M.D., Hot Springs
      - District #8:  
David L. Barclay, M.D., Little Rock  
R. Jerry Mann, M.D., Little Rock  
Harold D. Purdy, M.D., Little Rock
      - District #9:  
Robert H. Langston, M.D., Harrison  
(Entitled to another councilor 12/31/91)
      - District #10:  
Morton C. Wilson, M.D., Fort Smith  
Gerald A. Stolz, M.D., Russellville
    - Delegates to the AMA (Term 1/1/93-12/31/94):  
John P. Burge, M.D., Lake Village  
Asa A. Crow, M.D., Paragould





Alternate Delegates to the AMA (Term 1/1/93-12/31/94):

David L. Rogers, M.D., Fayetteville

John M. Hestir, M.D., DeWitt

William N. Jones, M.D., Little Rock

3. Address by Past President of the Arkansas Medical Society, George Warren, M.D.
4. Reports of Reference Committees:  
Committee #1  
Committee #2
5. Supplemental report of the Council:  
Charles Logan, M.D., Chairman  
(Report covers meetings of the Council held during the annual session.)
6. New Business:  
Announcement of nominees for the Arkansas State Medical Board and the Arkansas State Board of Health.  
Other new business

### State Board Vacancies

#### Arkansas State Board of Health

A vacancy will occur December 31, 1992, in the First and Fifth Congressional Districts of the Arkansas State Board of Health. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. The term of office is four years. Nominations should be reported to Kay Waldo, Director of Administrative Services, immediately following the caucuses (only one nomination is required).

**First Congressional District:** Don B. Vollman Jr., M.D., of Jonesboro, is currently serving the term which will expire in December, 1992. Dr. Vollman is eligible to succeed himself.

Counties in the First Congressional District include Clay, Craighead, Crittenden, Cross, Greene, Lee, Mississippi, Phillips, Poinsett and St. Francis.

**Fifth Congressional District:** James Maupin, M.D., of Dardanelle, is currently serving the term which will expire in December, 1992. Dr. Maupin is eligible to succeed himself.

Counties in the Fifth Congressional District include Conway, Faulkner, Perry, Pope, Pulaski and Yell.

#### Arkansas State Medical Board

A vacancy will occur December 31, 1992, in the Fourth Congressional District position of the Arkansas State Medical Board. The term of office will be for eight years. Members from the counties in the district are urged to meet immediately following the adjournment of the House of Delegates on Thursday to vote for nominees. Nominations should be re-

ported to the Society personnel immediately following the caucuses (only one nomination is required).

**Fourth Congressional District:** George Wynne, M.D., of Warren, is currently serving the term which will expire, December, 1992. Dr. Wynne is eligible to succeed himself.

Counties in the Fourth Congressional District include Ashley, Bradley, Calhoun, Clark, Columbia, Hempstead, Howard, Little River, Lafayette, Miller, Montgomery, Nevada, Ouachita, Pike, Polk, Sevier and Union.

### Meetings of the Council

The Council will meet at the following times:

Thursday, April 9	3:00 p.m.
Friday, April 11	4:30 p.m.

If needed, a third Council meeting will be called at the discretion of the Chairman.

### Reference Committees

Reference Committees are appointed by the Speaker of the House of Delegates to consider the various reports and resolutions. Reports published in this issue of *The Journal*, as well as any reports and resolutions presented at the first meeting of the House on April 9th, will be referred by the Speaker to the reference committees. The committees will hold open hearings at 8:00 a.m. on Friday, April 10th. After the hearings, the reference committees will hold executive sessions for the purpose of preparing recommendations and reports for the House of Delegates. Reports of the Reference Committees will be acted upon by the House of Delegates at the Saturday session.

### "AROUND THE WORLD"

... and around the Exhibit Center. Come visit with the 1992 Exhibitors in Governor's Hall II at the Excelsior Hotel in Little Rock during the AMS 116th Annual Session. Sample the hors d'oeuvres from around the world, which are sponsored by *Continental Medical Systems*. What a wonderful way to round out a Friday afternoon. Plan on being there!





# Nominating Committee

## Nominating Committee

**Charles Logan, M.D., Chairman**

The Nominating Committee met September 7, 1991, at the Arkansas Medical Society office in Little Rock and by conference call on September 24, 1991.

We wish to present to the Society the following nominees:

**President-elect:**

Glen F. Baker, M.D., Little Rock

**Vice President:**

Steve Schoettle, M.D., West Memphis

**Treasurer:**

Lloyd G. Langston, M.D., Pine Bluff

**Secretary:**

Charles H. Rodgers, M.D., Little Rock

**Speaker of the House:**

John Crenshaw, M.D., Pine Bluff

**Vice Speaker of the House:**

Position available

**Councilors:**

**District #1:**

Dwight Williams, M.D., Paragould

**District #2:**

Michael N. Moody, M.D., Salem

**District #3:**

Samuel A. McGuire, III, M.D., Forrest City

**District #4:**

Paul A. Wallick, Monticello

**District #5:**

Robert H. Nunnally, M.D., Camden

**District #6:**

James D. Armstrong, M.D., Ashdown

**District #7:**

Ronald J. Bracken, M.D., Hot Springs

**District #8:**

David L. Barclay, M.D., Little Rock

R. Jerry Mann, M.D., Little Rock

Harold D. Purdy, M.D., Little Rock

**District #9:**

Robert H. Langston, M.D., Harrison

(Entitled to another councilor 12/31/91)

**District #10:**

Morton C. Wilson, M.D., Fort Smith

Gerald A. Stolz, M.D., Russellville

**Delegates to the AMA (1/1/93-12/31/94):**

John P. Burge, M.D., Lake Village

Asa A. Crow, M.D., Paragould

**Alternate Delegates to the AMA (1/1/93-12/31/94):**

David L. Rogers, M.D., Fayetteville

John M. Hestir, M.D., DeWitt

William N. Jones, M.D., Little Rock

## Nominating Committee Supplemental Report

**Charles Logan, M.D., Chairman**

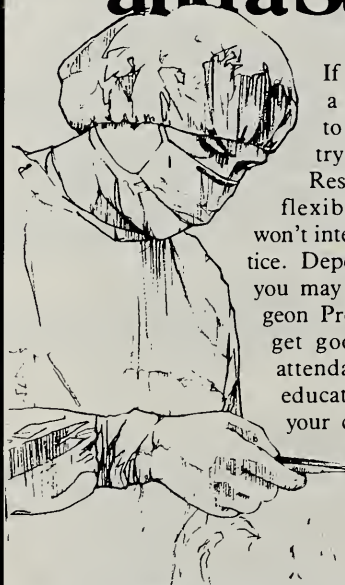
In the event of the election of Lloyd Langston, M.D., as Treasurer, the Fourth Councilor District recommends Anna T. Ridling, M.D., to complete Dr. Langston's unexpired term as councilor ending April 1993.

## Addendum to the Nominating Committee Report

**Charles Logan, M.D., Chairman**

The Nominating Committee would like to suggest the following criteria for the position of Vice President: a) the nominee be in medical practice less than ten years; b) term of office will be for one year; c) the nominee cannot succeed himself in office; and d) the vice presidential duties shall include working with the Arkansas Medical Society staff in the area of membership in addition to regular Council duties. The Nominating Committee request that this criteria be referred to a Reference Committee for consideration during the 1992 annual meeting.

## An Officer and a Surgeon



If you're a surgeon looking for a change of pace and a chance to sharpen your surgical skills, try your hand in the Air Force Reserve. Serve part-time. Our flexible participation schedule won't interfere with your private practice. Depending on your experience, you may qualify for the Flight Surgeon Program. As an officer, you'll get good pay, benefits and paid attendance to continuing medical education (CME) activities. Serve your country. Serve yourself. For more information, call (404)421-4892. Today's Air Force Reserve...it's a great way to serve.

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# Business Reports

## Task Force on AIDS

**Joseph M. Beck II, M.D., Chairman**

The AMS Task Force on AIDS held seven formal meetings during 1991. During 1991, the Task Force members have been: Drs. Joseph Beck II, Chairman; Jim Acklin, Susan Beland, Barbara Bozeman, A. Stuart Fitzhugh, Donald C. Fournier, Harold Hedges, Charles Henry Sr., William N. Jones, Linda A. McGhee, E. Clinton Texter Jr., and J. Douglas Wilson. Other committee members include: Mrs. Arleta Power, AMS Auxiliary representative; Scott Stanley, AMS Medical Student representative; and Fred Church, D.D.S., Arkansas State Dental Association representative.

The number of AIDS cases continued to rise in women, especially of childbearing age, and the Task Force is attempting to address this issue. In the United States, there have been 202,843 AIDS cases reported to the Center for Disease Control since 1981 and over 130,687 deaths.

During 1991, 51 educational programs were conducted on AIDS, which included presentations by the medical student program F.A.T.E. (Fighting AIDS Through Education). The Task Force collaborated with the Arkansas Department of Health, Arkansas State Dental Association, Arkansas Nurses Association, American Medical Association, Nurses Oncology Society, Regional AIDS Interfaith Network, and U.S. Congress.

In February, 1991, The Task Force on AIDS surveyed Arkansas hospitals about their written policies concerning HIV-infected health care workers. Fifty-one hospitals returned the questionnaire and the following were the results:

- Hospitals which have policies ..... 18
- Hospitals which do not have a policy, but are currently considering a policy ..... 18
- Hospitals which do not have a policy and are not currently composing one ..... 15

Approximately one-third of the 51 respondents did not have a policy at that time.

On April 27, 1991, over 250 health professionals attended the Fourth Annual AIDS Seminar in Hot Springs. The keynote speaker was Dr. Julie Gerberding, an infectious disease specialist from San Francisco General Hospital in California. The program also included Dr. Daniel Seckinger III from Miami, Florida, who addressed the Florida dental case.

AMS was victorious in the 1991 Arkansas Legislative Session concerning the issue of AIDS. A law was passed (Act 575) which requires confirmatory testing and reporting of positive HIV donors by blood or plasma centers. Also, the HIV Shield Law (Act 289) was passed which provides that written consent is not a requirement for physicians to perform HIV testing when necessary under his/her medical judgement.

In August, 1991, the Task Force began planning the Fifth Annual AIDS Seminar which will coincide with the AMS Annual Session in Little Rock on April 11, 1992. The keynote speaker will be Dr. Brady Allen of Dallas, Texas.

Also passed in 1991, was House Concurrent Resolution 1011, which expressed opposition to the proposed U.S. Department of Human Services regulation which removed HIV infection from the Department of Immigration list of communicable diseases. Dr. Jones, as 1990-91 AMS president, wrote to all state societies asking them to support this position.

During 1991, the following articles were published in the *The Journal of the Arkansas Medical Society*:

"AIDS Related Lymphoma"  
by Joseph Beck II, M.D.

"Tuberculosis and HIV"  
by Donald C. Fournier, M.D.

"Tuberculosis and HIV Addendum"  
by Joseph Beck II, M.D.  
and Donald C. Fournier, M.D.

"HIV: Risks to Health Care Workers and Risk Reduction"  
by Julie Gerberding, M.D., M.P.H.

"Use of Hematopoietic Growth Factors in Patients with HIV Disease"  
by Joseph Beck II, M.D.

"Recommendations for Preventing Transmission of HIV and HBV to Patients During Exposure-Prone Invasive Procedures"  
by the Center for Disease Control

"The Florida Dental Case"  
by Donald C. Fournier, M.D.



## Annual Session Committee

**Glen F. Baker, M.D., Chairman** \_\_\_\_\_

The 1991 Annual Session was held in Hot Springs at the Arlington Hotel. Topics for the meeting included: "Medicare Frustrations - A Doctor Fights Back," "Federal Medicaid Mandates - Enhancing State Control over Medicaid Programs," "Improving Access to Health Care Through Medicaid," "The Doctor Has AIDS: A Patient's Rights to Know," and "HIV: Health Care Workers' Issues."

John Ebensberger, M.D., of Greene, Iowa, told his story of "what happens when the only doctor in town refuses to succumb to the Medicare bureaucracy." Tim Gibson, director of Public Relations for the Iowa Medical Society, joined the discussion to explain the reaction of colleagues and the response from Medicare administrators. U.S. Representative William E. Dannemeyer, a republican from California, addressed federal Medicaid mandates and how to enhance state control over programs.

Terry Yamauchi, M.D., and Mr. Kenny Whitlock explained a recently passed innovative Medicaid program. Daniel Seckinger III, a pathologist from Miami, Florida, and a consultant for the Centers of Disease Control, reviewed the nationally publicized Florida dental case of a dentist who was accused of transmitting AIDS to three patients. The continued risk of HIV infection to health care workers was discussed by Julie Gerberding, M.D., director of HIV Counseling and Testing Services at the San Francisco General Hospital, and assistant Professor of Medicine at the University of California.

Attending the exhibit hall, meetings, and banquets were 451 physicians and spouses. One hundred seventy exhibitors from 63 companies worked the exhibits. Thanks to sponsorships, grants, and exhibitor fees the annual session was "Full Steam Ahead."

## The Changing World of Medicine



**Arkansas Medical Society  
116th Annual Session**

## Report on the Articles of Incorporation

**Ken LaMastus, AMS Executive Vice President** \_\_\_\_\_

The following represents Amended and Restated Articles of Incorporation of Arkansas Medical Society, Inc. Arkansas Medical Society original articles of incorporation were filed October 11, 1929. These amended and restated articles represent the recommendation of our attorneys. They bring us into modern times. Our articles of incorporation include mention that the Society has the right to own land, corporate stock, and those things necessary for the Society in today's world. Nothing herein changes our Constitution and Bylaws or provides powers to an individual or group within the Society not already provided for in our Constitution and Bylaws.

### **Amended and Restated Articles of Incorporation of Arkansas Medical Society, Inc.**

The undersigned natural persons, over the age of eighteen (18) years, do hereby amend and restate, in accordance with the Arkansas Nonprofit Corporation Act (the "Act") and the Arkansas Business Corporation Act of 1987, the Articles of Incorporation for Arkansas Medical Society, Inc.

#### **ARTICLE I**

The name of the corporation is Arkansas Medical Society, Inc.

#### **ARTICLE II**

The corporation is a nonprofit corporation.

#### **ARTICLE III**

The period of its duration is perpetual.

#### **ARTICLE IV**

The purposes for which the corporation is organized and the activities proposed to be transacted, promoted and carried on by it are:

- A. To federate and bring into one compact organization the entire medical profession of the State of Arkansas and to unite with similar societies of other states to form the American Medical Association;
- B. To extend medical knowledge and advance medical science;
- C. To elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws;
- D. To promote friendly intercourse among physicians;
- E. To guard and foster the material interests of its members and to protect them against imposition;
- F. To enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the



public in the prevention and cure of disease, and in prolonging and adding comfort to life;

- G. To maintain medical ethics and to secure compliance with the art and science of medical practice;
- H. To conduct programs that improve the health and quality of life for all people; to promote health education; to undertake and to aid, promote, develop and advance education and research relating to the study, teaching and practice of the medical sciences; and to promote, encourage, assist, finance and administer and execute such programs and projects as may be desirable for the effective realization of the objectives and purposes herein set forth and the accomplishment thereof;
- I. To accept money and funds of every kind of gifts, grants, bequests or otherwise; to solicit membership dues and contributions from its members for the exclusive benefit of the corporation;
- J. To issue bonds, debentures, notes or other obligations of the corporation, and to secure the same by mortgage, pledge, deed of trust or otherwise as may be desirable for the effective realization of the objectives and purposes herein set forth and the accomplishment thereof;
- K. To acquire, purchase, own, hold, operate, develop, improve, lease, mortgage, pledge, exchange, sell, transfer or otherwise invest, trade or deal in securities, stocks, mortgages, bonds, notes and other personal property and real property as may be desirable for the effective realization of the objectives and purposes set forth and the accomplishment thereof;
- L. To do any and all things necessary, suitable or proper for the accomplishment of any of the purposes, the attainment of any of the objectives of the furtherance of any of the powers enumerated in these Articles of Incorporation, or any amendments thereto; and to carry on any lawful activity necessary or incidental to the attainment of the objectives of the corporation, whether or not such activity is similar in nature to the objectives set forth in these Articles of Incorporation or any amendments; and
- M. To carry out any other activity similar in purpose, intent and effect to the foregoing that reasonably tends, consistent with Section 501(c)(6) of the Internal Revenue Code of 1986, as amended, and the Arkansas Nonprofit Corporation, as amended to protect the rights and advance the interests of the corporation.

## ARTICLE V

The street address of the main office of the corporation is No. 10 Corporate Hill Drive, Suite 300, Little Rock, Arkansas 72205, and the name of its registered agent at such address is Ken LaMastus.

## ARTICLE VI

- A. Except as restricted or prohibited by law, the affairs of the corporation shall be operated in accordance with its Bylaws. The corporation's affairs shall be managed by the Council. Members of the Council shall be elected by a majority of the House of Delegates. Each member of the House of Delegates shall be selected by the members of the corporation residing in their separate district. The number of members constituting the Council of the corporation shall be not less than ten (10) nor more than fifty (50). The number of members constituting the current Council is thirty-three (33) and the names and addresses of the persons serving as the Council members are:

Charles Logan  
Chairman  
500 S. University, #512  
Little Rock 72205

George Warren  
President  
PO Box "A"  
Smackover 71762

J. Larry Lawson  
President-elect  
#1 Medical Drive  
Paragould 72450

Charles Rodgers  
Secretary  
4202 S. University  
Little Rock 72204

James M. Kolb Jr.  
Treasurer  
115 Skyline Drive  
Russellville 72801

William N. Jones  
Immediate Past President  
500 S. University, #708  
Little Rock 72205

Michael N. Moody  
Vice President  
Family Clinic, Hwy 9 North  
Salem 72576

John Crenshaw  
Speaker of the House  
4201 Mulberry  
Pine Bluff 71603

Dwight Williams  
#1 Medical Drive  
Paragould 72450

Merrill Osborne  
10th & Highland, #C  
Blytheville 72315

John Bell  
1300 S. Main  
Searcy 72143

Lloyd G. Bess  
1490 Byers  
Batesville 72501

L.J.P. Bell  
626 Poplar  
Helena 72342

Hoy Speer  
1708 N. Buerkle  
Stuttgart 72160

Paul Wallick  
906 Roberts Drive  
Monticello 71655

Lloyd Langston  
PO Box 1550  
Pine Bluff 71613

Robert Nunnally  
PO Box 186  
Camden 71701

Wayne Elliott  
443 W. Oak  
El Dorado 71730

James Armstrong  
PO Box 637  
Ashdown 71822

F. E. Joyce  
PO Box 2763  
Texarkana, TX 75504



Ronald Bracken  
1401 Malvern, #100  
Hot Springs 71901

Thomas Hollis  
125 Greenwood  
Hot Springs 71901

David Barclay  
500 S. University, #614  
Little Rock 72205

Glen Baker  
800 Marshall  
Little Rock 72202

R. Jerry Mann  
521 S. Elm  
Little Rock 72205

Paul Cornell  
500 S. University, #413  
Little Rock 72205

Harold Purdy  
6924 Geyer Springs  
Little Rock 72209

Robert Shannon  
650 S. Shackelford, #217  
Little Rock 72211

Robert Langston  
P.O. Box 1350  
Harrison 72602

David Rogers  
1792 Joyce, #3  
Fayetteville 72703

Morton C. Wilson  
6802 S. "U" Court  
Fort Smith 72903

Paul Wills  
600 S. 16th  
Fort Smith 72901

Gerald Stolz  
PO Box 925  
Russellville 72801

Hawkins, J.G. Gladden, R.J. Calcote, W.R. Bathhurst,  
W.W. Verser, L.T. Evans, M.C. John, W.T. Low, L.L.  
Purifory, C.A. Archer, Dewell Gann Sr., Anderson  
Watkins, W.H. Poynor, and S.J. Wolfermann.

## ARTICLE IX

- A. No part of the net earnings of the corporation shall inure to the benefit of or be distributed to its members, House of Delegates or Council members, officers or other private persons, except that the corporation may pay reasonable compensation for services actually rendered and shall make payments and distributions in furtherance of the purposes set forth in Article IV. Notwithstanding any other provision of these Articles, the corporation shall not carry on any activity not permitted to be carried on by a corporation exempt from taxation under Section 501(c)(6) of the Internal Revenue Code of 1986, as amended.
- B. Upon the dissolution of the corporation, unless otherwise required by the Act or the Internal Revenue Code of 1986, as amended, the Council shall, after paying or making provision for the payment of all of the liabilities of the corporation, distribute the net assets of the corporation to such organizations as the Council may determine provided such organizations are organized for purposes described in Sections 501(c) of the Internal Revenue Code of 1986, as amended.
- C. The Council is expressly authorized, in its discretion, to amend or alter these Articles of Incorporation or any Bylaws adopted by the corporation in any respect necessary to maintain status under the Internal Revenue Code of 1986, as amended, as an organization exempt from income tax under Section 501(c)(6).

- B. The term of office of each member of the Council and the House of Delegates shall be one year or such other period established by the Bylaws.

## ARTICLE VII

- A. The corporation may indemnify, to the fullest extent permitted by law, a person who was, is, or is threatened to be named a defendant or respondent in a proceeding because the person is or was a member of the House of Delegates or Council, officer, employee, agent or volunteer of the corporation.
- B. The corporation may purchase and maintain, to the fullest extent permitted by law, insurance on behalf of any person who is or was a member of the House of Delegates or Council, officer, employee, agent or volunteer for the corporation or who is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against any liability asserted against him or incurred by him in such capacity, or arising out of his status as such, whether or not the corporation would have the power to indemnify him against such liability under applicable law.

## ARTICLE VIII

The names of each original incorporator are:  
Thad Cothorn, E.E. Barlow, George B. Fletcher, B.H.

IN WITNESS WHEREOF, we have hereunto set  
our hands this \_\_\_\_ day of \_\_\_\_\_, 1992.

\_\_\_\_\_  
President

\_\_\_\_\_  
Secretary



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**Budget Committee****Merrill Osborne, M.D., Chairman** \_\_\_\_\_

The Budget Committee submitted the following budget for 1992. The complete budget, as presented to the Council, is available to members upon request.

<i>Income</i>	<i>Amount Budgeted</i>
AMS dues and MEFFA	\$571,862.00
Journal Advertising	80,000.00
Booth Income 1992	35,000.00
Annual Session	32,000.00
AMA Reimbursement	6,000.00
Miscellaneous & Rosters	10,000.00
Interest Income	58,000.00
Specialty Desk	2,400.00
Continuing Medical Education	1,700.00
Rent, FO & Land Income	23,000.00
Allocation of GA Dept.	5,000.00
Educational Programs	<u>12,000.00</u>
Total	\$836,962.00

*Expenses*

Salaries	\$242,232.00
Travel & Convention	50,000.00
President's Account	6,500.00
Taxes	25,000.00
Retirement	28,500.00
Stationery & Printing	13,500.00
Office Supplies & Expenses	20,000.00
Telephone & Telegraph	10,000.00
Rent	95,000.00
Postage	23,000.00
Insurance and Bonds	51,000.00
Auditing	4,750.00
Council & Executive Committee	4,750.00
Journal Expenses	65,500.00
Dues & Subscriptions	3,000.00
Gifts & Contributions	2,200.00
Auxiliary	2,000.00
Legal Services (Retainer)	27,426.00
Special Committee	1,000.00
Public Relations	3,000.00
Miscellaneous Expenses	4,000.00
Office Equipment & Furniture	6,000.00
CME	1,000.00
Richmond Early Retirement	5,820.00
Contract Labor	500.00
Winter Meeting	2,000.00
AMS Resident & Student Section	5,500.00
AIDS Committee	2,000.00
Annual Session 1992	63,000.00
Educational Programs	6,000.00
AMS Building Fund	30,000.00
Physicians' Health Committee	10,000.00
MEFFA Dues	<u>9,500.00</u>
Total	\$823,678.00

**Department of Governmental Affairs**

<i>Income</i>	\$191,900.00
<i>Expenses</i>	
Salaries	\$87,692.00
Retirement	10,100.00
Taxes	7,400.00
Stationery & Printing	4,200.00
Office Supplies, Teleph. & Misc.	4,200.00
Equipment & Furniture	1,500.00
Auto, Travel & Meetings	42,000.00
Legal Retainer	18,300.00
Postage	7,500.00
Insurance & Bonds	8,000.00
Office Allocation to AMS	5,000.00
Audit	<u>750.00</u>
Total	\$196,642.00

**Report of the Council****Charles W. Logan, M.D., Chairman** \_\_\_\_\_**AMS Council**

The Council met March 3, 1991, and the following business was transacted:

1. Approved the minutes of the October 28, 1990, Council meeting.
2. Approved the minutes of the November 28, 1990, Executive Committee meeting.
3. Approved the minutes of the January 9, 1991, Executive Committee conference call.
4. Approved the minutes of the January 23, 1991, Executive Committee meeting.
5. Approved the minutes of the February 9, 1991, Executive Committee meeting.
6. Mr. Bill Bowen discussed the Arkansas Research Center.
7. Received reports on the PRO at the state and national levels.
8. All officers and councilors were encouraged to wear the new AMS pocket crest. Displaying the crest enforces unity among our officers and membership.
9. The Auxiliary's statewide Adolescent and Teen Health Conference was discussed. A request for financial support was deferred to the next Executive Committee meeting.
10. Received reports on the AMA Interim Meeting and the Leadership Conference.
11. Requirements for certifying rural health clinics was outlined by Val Buck, director, Division of Health Facilities, Arkansas Department of Health.
12. An outline of the proposed Workers' Compensa-



tion Commission fee schedule was given.

13. Appreciation was expressed to Mr. Lynn Zeno, Mr. Mike Mitchell, and all the physicians who have worked so hard to make this a successful legislative session.
14. An update was given on the bills still pending in the legislature.
15. Dr. William Jones expressed appreciation to the members of the Council who have worked hard during the legislative session. He also expressed his concern about the low number of physicians who have contributed to MED-PAC. To encourage contributions, Dr. Jones stated that each person who contributed \$250 or more to MED-PAC would be given an AMS pocket crest.

Report of the April 25 and April 26, 1991 Council meetings were printed in the June 1991 issue of *The Journal of the Arkansas Medical Society*.

The Council met July 28, 1991, and the following business was received and transacted:

1. Appointments to the Arkansas State Medical Board and Arkansas State Board of Health were discussed along with the old six congressional districts. New members of the Council were introduced.
2. Approved the minutes of the April 25 and 26, 1991, Council meetings.
3. Approved the minutes of the May 22 and June 26, 1991, Executive Committee meetings.
4. Reports were received on the activities of the AFMC. Dr. James Armstrong is serving as chairman of the board and Dr. Morton Wilson as assistant medical director.
5. Received a report on the AMS Auxiliary's DWI Statewide project and the Adolescent Health Project.
6. Received reports on the AMA meeting in Chicago.
7. Received a report from the Task Force on Immunization. The Council agreed to support the delivery of CDC supported vaccine by the Health Department to private physicians that wish to participate.
8. The new implant birth control method, Norplant, was discussed. The Council approved having Mike Mitchell, AMS Legal Counsel, review legal qualifications of nurse practitioners and physician assistants who may use Norplant. The Health Department policy on Norplant was also presented.
9. The results of the investigation regarding residency service for active service during Desert Storm was presented.
10. A resolution from the Baxter County Medical

Society concerning laboratory guidelines established by Blue Cross was presented. The Council supported the resolution.

11. Accepted the following position papers as presented: MEFFA and the Financial Policy of the Arkansas Medical Society.
  12. Received an update on the activities of the Physician's Health Committee.
  13. Received an update on federal legislation, RBRVS, and the new Medicaid fee schedule. The possibility of a lawsuit concerning the CLIA 88 Rules was discussed. The Council directed the Executive Committee to discuss limitation of medical visits with Dr. Terry Yamauchi.
  14. Received renewal information on the AMS group health plan.
  15. Received the MEFFA audit for information.
  16. Received a report on the 1991 Annual Session. It was noted that this was the third year in a row that the session was profitable.
  17. Appointed Dr. Dwight Williams of Paragould as a first district councilor to fill the unexpired term of Dr. Larry Lawson.
  18. Received the budget and membership reports for the period ending June 30, 1991.
  19. Approved requests from several AMS members for membership dues exemption.
  20. Dr. George Warren urged the councilors and past presidents to join the MED-PAC President's Club.
- The Council went into executive session.

The Council met September 15, 1991, and the following business was received and transacted:

1. Approved the minutes of the July 28, 1991 Council meeting and executive session, and the August 28, 1991 Executive Committee meeting.
2. Received a report on the AMS Building, how it was developed by limited partnership, and the current financial status of the building.
3. Rhett Tucker of Flake and Company expressed their opinion that on a long-term basis the property looks good and that the building has maintained over a 90% occupancy rate the last four years.
4. Received for information the real estate appraisal on the AMS Building along with a copy of a letter from Pyron and Associates.
5. Approved a motion to appoint a committee which would include a legal counsel, Dr. Paul Wallick, a certified public accountant, a member of the Council, Ken LaMastus, an investment partner, and Dr. John Crenshaw. The committee would study solutions which may include some investment from the Society and that may also salvage the investment to whatever extent



possible of the limited partners. The committee will be asked to report back to the Council.

6. Amended the motion for the investment partner to serve as an ex-officio.

The Council met November 24, 1991, and the following business was received and transacted:

1. Approved the minutes of the September 15, 1991 Council meeting.
2. Approved the minutes of the August 28, 1991 Executive Committee meeting.
3. Approved the minutes of the October 23, 1991 Executive Committee meeting.
4. Approved a letter concerning the Physicians' Health Committee that will be mailed to AMS members who have insurance through St. Paul.
5. An overview was given of the appointments to the State Medical Board, who is serving on the board, and how they are appointed.
6. Received the results of a study conducted on a new insurance program for AMS members. The Council instructed the Executive Committee to implement the plan.
7. Dr. James Busby's resignation will become effective in the spring. Resumes should be forwarded to Fort Smith. The Quality Intervention Plan was also discussed.
8. Received for information the AMS Membership Report.

The Council went into executive session to discuss the budget for 1992 and the AMS Building.

#### *AMS Executive Committee*

The Executive Committee met by conference call January 9, 1991 and the following business was received and transacted:

1. Discussed the proposed Provider Excise Tax that would impose a 15% tax on the state portion of Medicaid payments to providers. The 15% tax on the state portion of Medicaid payments, which constitutes about 25% of the payment and the other 75% is paid by the federal government, would then represent 3.75% of the total payment. If the program is implemented, the state of Arkansas would have a greater amount of money to match with the federal money. The plan also calls for the legislature to appropriate an additional \$30 million to match the \$30 million excise tax for a total of \$60 million in state money to match the feds.  
Under this program physicians will get fee increases in nearly all cases that would equal the Blue Cross Blue Shield rates.
2. Discussed that Dr. Ray Jouett's term on the Medical Board expired December 31, 1990, and the Governor had not reappointed Dr. Jouett as

recommended by the House of Delegates. Recommended that a letter with Dr. Jones' signature be hand delivered confirming the Medical Society's support of Dr. Jouett.

3. Endorsed funding for the Poison Control Center which will be operated by the College of Pharmacy at UAMS.

The Executive Committee met January 23, 1991 and the following business was received and transacted:

1. Endorsed a request from the Adjutant General of the Arkansas National Guard for the Medical Society to encourage all physicians to accept CHAMPUS. Many of the families of those servicemen now serving in Operation Desert Storm are currently covered by CHAMPUS.
2. Endorsed a request from Dr. John Hestir that we have someone explain the Rural Health Clinic's concept at the next Council meeting.
3. Reviewed information about the Bare Bones Insurance bill introduced in the legislature. It was noted that the bill appeared to be drafted by Arkansas Blue Cross Blue Shield for Arkansas Blue Cross Blue Shield. It would not seemingly have allowed virtually any other insurance company to write this type of insurance in Arkansas.
4. Reviewed information concerning the Provider Tax and its implication on the Medicaid program in Arkansas. It was noted that the Governmental Affairs Council had been given the authority from the Arkansas Medical Society to join with other health care groups in support of this legislation.
5. Reviewed regulations being developed by the Arkansas State Board of Pharmacy requiring pharmacists to provide consultation to patients at the time they get their prescriptions and to meet with all patients being discharged from the hospital for purposes of counseling them on drug use.
6. Received a report from Blue Cross Blue Shield that Medicare had impounded funds necessary to implement the new changes in the federal law pertaining to Medicare. This impounding of funds would cause Arkansas Blue Cross Blue Shield to hold all non-electronically filed claims for a period of 60 days before paying (since that time, the Health Care Financing Administration has released these funds which should allow for more time in paying these claims under Medicare).
7. Received information on the following topics: (1) Arkansas Health Care Access Foundation study; (2) the State Board of Pharmacy Regulations; (3)



the Arkansas Medical Society's Legislative Directory; (4) Provider Tax; and (5) an AMA printout concerning HIV infected physicians.

The Executive Committee met February 9, 1991, and the following business was received and transacted:

1. Considered the proposed Workers Compensation Fee Schedule. Background: Late last year (1990), the Workers Comp Commission asked the AMS to recommend a method of establishing a Workers Compensation fee schedule. In making this request, the Commission cited building pressure from labor and business for a legislative solution. Since a regulatory solution was much more to our advantage, a special AMS committee was established. Appointed to the Workers Compensation Special Committee were: Drs. James Kolb Jr., chairman; George Warren; Hugh Burnett; Morrison Henry; and Harold Chakales. The committee was to develop a method of establishing a fee schedule which could be utilized by Workers Compensation and one that would meet the approval of physicians. The task had to be completed prior to the end of the 1991 General Assembly to avoid the potential legislated fee schedule. The special committee met on three separate occasions. After reviewing Workers Compensation fee schedules from several states, the committee has recommended a relative value scale as the most acceptable approach. The committee is suggesting that a RVS published by McGraw-Hill, titled *Relative Values For Physicians* be used as a starting point. In order to determine whether this method would be acceptable to physicians, a special session of the Medical Services Review Committee was convened on February 9, 1991. The AMS staff and special committee presented their recommendations including a list of the top 124 CPT codes (by frequency) and what the fees would be under the proposal.
2. The MSRC approved the RVS method of establishing the fee schedule and agreed to serve as a review body for unusual or difficult claims.
3. Approved the committee's recommendations.

The Executive Committee met March 27, 1991, and the following business was received and transacted:

1. Recommended writing Mr. Lynn Zeno a letter of accommodation for his work in the recent legislative session.
2. Reviewed information pertaining to the Arkansas Research Center. The Committee endorsed the program and referred the question of contribu-

tions to the Budget Committee.

3. Gave unanimous support for the Auxiliary's statewide health conference for adolescents and teens.
4. Suggested that Mike Mitchell, AMS Legal Counsel, consider writing a letter to the United States Attorney requesting an investigation of the release of confidential AMFC correspondence to Jefferson Regional Medical Center.
5. Reviewed information pertaining to the lawsuit concerning a hospital's contract with Blue Cross. Information included the judge's ruling for the case between St. Mary Hospital in Russellville and Blue Cross.
6. Requested that information be put in the newsletter concerning third-party review. The Committee wanted the members to be reminded again that this legislation had passed and suggested putting additional information in *The Journal* regarding the legislation and regulations.

The Executive Committee met May 22, 1991, and the following business was received and transacted:

1. Reviewed a letter from the Department of Human Services concerning the peer review process that the Executive Committee performs for the Medicaid program.
2. Recommended that Mike Mitchell, Kenny Whitlock, Dr. Terry Yamauchi, Roy Jeffus, and Dr. Ray Jouett discuss future direction of the utilization review process for Medicaid at the next regular Council meeting.
3. Recommended that a request from Dr. David Busby for partial funding to attend an AMA Campaign Management School be referred to MED-PAC because this involves political campaigns.
4. Efforts to find a replacement for Peggy Cryer, director of Administrative Services was discussed.
5. Received a report on a meeting with representatives from Flake and Company. The building is having financial problems which may involve the Society not getting its rate reduction as required in the AMS lease. The reduction would come at the end of a six-year lease. Some of the problems with the building are occurring because of the slow economy and the fact that leasing of the building space is running about \$12 per square foot, whereas it was estimated to be leasing for about \$14 or \$15 per square foot at this time.
6. Recommended that Dr. Susan Beland, an internist, be appointed to the MSRC. Dr. Lee Abel declined the nomination.
7. Received a report on the annual session. Dr. Baker reported that all the comments he had



received about annual session had been very positive. Preliminary figures showed that income would be approximately \$64,697.50 and actual expenses would be approximately \$59,882.40. Dr. Baker mentioned that a few of the room and expense items have not been received and a final report would be given at the next Council meeting. As reported over the last three years, the annual session has either made a profit or broke even. Up until Dr. Baker became chairman and a new format was put into place, the Society had been losing about \$20,000 a year on the convention.

8. Dr. Glen Baker, who chairs the committee to review a possible plan for the Society to develop a self-insured health care plan, recommended that Mr. Fred Bean be hired as a consultant to develop the pros and cons in the technical steps necessary to develop a self-insured plan. Part of his report should include the risks associated with a completely self-insured plan as well as some form of insurance through a company writing AMS as a group. The Executive Committee approved Mr. Bean's consultant fee of \$2,000. The Budget Committee will be asked to approve of this expenditure since this project was not included in this year's budget.
9. Recommended that Dr. George Warren, who is now serving as AMS president, write a letter of commendation to Ms. Cryer for her work with the Arkansas Medical Society.
10. Ken LaMastus reminded the committee of previous correspondence mailed to them about a HCFA representative who inquired about things that HCFA may have developed that are a nuisance to physicians. The indication was that they would attempt to do something about some of those things but nothing could be done about funding. The committee was reminded that this was the first time ever HCFA had solicited comments from the Medical Society concerning possible problems that physicians have with Medicare or Medicaid. The Executive Committee reaffirmed the phone poll agreeing for the Arkansas Medical Society to join with the AMA and some Arkansas physicians to obtain a temporary restraining order against HCFA. This would prevent the apparent illegal attempt to collect fees under CLIA 1988.

The Executive Committee met June 26, 1991, and the following business was received and transacted:

1. Received a report from John Flake concerning the cash flow problem being experienced with the AMS Building. It was pointed out that the building will need approximately \$10,000 by the

end of July. Flake & Company is to come up with some suggestions and present them to Ken LaMastus to be discussed with the Executive Committee and the Council.

2. A resolution was signed allowing Kay Waldo, the new director of Administrative Services, to sign checks for the AMS.

The Executive Committee met July 28, 1991, and the following business was received and transacted:

1. Received an update on the consideration of a self-insured health plan.
2. Received a report from Mr. Fred Bean of Bean, Hamilton, and Associates and discussed the feasibility of a Society coordinated group health insurance plan.
3. Recommended that the AMS survey medical clinics to determine interest in the insurance plan.
4. Recommended funding for the survey in the form of a loan from the AMS to be repaid by insurance revenues.
5. Recommended that the Executive Committee research options for further consideration and possible solutions to the problems with the AMS Building.

The Executive Committee met August 28, 1991 and the following business was received and transacted:

1. Agreed to ask Medicaid to postpone the utilization review function that normally would have taken place in September until the normal meeting time in October. The postponement was due to Drs. George Warren and Charles Rodgers being out-of-state at an AAFP meeting.
2. Recommended that the Society contact Medicaid about payments for the last review.
3. Approved travel for Stephanie Percefull to attend the Sandoz Pharmaceutical Journalism Workshop in Los Angeles. Sandoz pays a portion of the expenses.
4. Approved travel for Dr. Joe Jones of Blytheville to attend the Drug Formulary Committee Group Meeting in Chicago. Dr. Jones serves on the state Medicaid Formulary Committee.
5. Approved travel expenses for Ken LaMastus to attend a state CEO's meeting in Virginia.
6. Reviewed a letter from the Feminist Majority Foundation concerning the campaign for RU 486 in contraceptive research. The Committee suggested writing a letter similar to the one written by Maine that says, in effect, the Arkansas Medical Society endorses the stand taken by the American Medical Association.
7. Approved travel for Lynn Zeno to attend the Rural Health Care: Strategies To Increase Access



meeting in Chicago.

8. Reviewed the situation concerning the AMS Building. The following recommendations were made: 1) the Council recommend a dues increase for an adequate number of years to pay the mortgage down on the building. Several details must be worked out first; 2) that Flake & Company meet with the partners on September 5, 1991, and with the Council on September 15, 1991; and 3) that Ken LaMastus prepare financial information of what would make the building mortgage workable.
9. Reviewed a request from Dr. Sanford Hutson of Blue Cross Blue Shield concerning a letter from the Executive Committee indicating that the Medical Society considers the Medical Services Review Committee the proper group to review those policy decisions that must be made by the Medicare carrier. The Committee pointed out that MSRC contains representatives from all fields of practice and has carried out this function since the inception of Medicare.

The Executive Committee met October 23, 1991, and the following business was received and transacted:

1. Approved Dr. Kenneth Beaton's request for emeritus dues-exempt status.
2. Approved a request from Dr. Gilmore, who is chairman of the Department of Anatomy at UAMS, to have a marker moved from its present location near I-630 and I-30 to the new UAMS building. The marker stated that in that particular location the first anatomical dissection was performed in Arkansas in 1874. The marker was placed in its current location by the AMS in 1927.
3. Dr. Glen Baker, chairman of the special committee for the AMS building, reported on specific recommendations that will be made to the Council.

The Executive Committee met November 27, 1991, and the following business was received and transacted:

1. Received information on the steps necessary to establish the self-insured health care plan. They include: 1) establishing the AMS Employee Benefit Trust; 2) establishing the AMS Benefits, Inc. (a for-profit corporation); and 3) establishing the AMS Insurance Agency which will be a department of AMS Benefits, Inc.
2. The following motions were made and approved:
  - 1) Establish the AMS Employee Benefit Trust [a 501(C)9 Corporation] administered by a Benefit Committee of five to seven members appointed by AMS Council. One or more of the members

would be nominated by the Arkansas Medical Group Management Association. 2) The Executive Committee approve the development of a for-profit subsidiary to be wholly owned by the AMS. Its board of directors to consist of seven individuals: The current, immediate, and past presidents of the AMS, the AMS treasurer, the AMS executive vice president, assistant executive vice president, and the AMS director of Governmental Affairs. The chairman of the board would be elected annually by the board; the president of the corporation would be the AMS executive vice president; the vice president and chief operating officer of the corporation would be the AMS assistant executive vice president; the secretary of the corporation would be AMS director of Governmental Affairs; the corporate treasurer would be the treasurer of AMS. The board will have all authority to make decisions relating to operations of AMS Benefits, Inc. (the for-profit subsidiary), render reports for information purposes to the AMS Council and/or House of Delegates.

3. Selected Bean, Hamilton, & Associates to be the organization which the for-profit would contract with to market the self-insured health plan and any insurance products endorsed by the AMS or the for-profit subsidiary.
4. Approved Provident Life & Accident Insurance Company's proposal to be the endorsed insurance carrier for disability and office overhead coverage.
5. Denied a request from MedTalk requesting that we participate in their program. MedTalk is an organization established to provide medical information to individuals calling in on a 900 number. It's pointed out that the cost of each minute of each phone call will be \$3.25. The Executive Committee suggested that Ken LaMastus communicate with these individuals and tell them the AMS wants no part of this organization in anyway.
6. Reviewed the tax deferred plan for employees endorsed by the American Association of Medical Society Executives. Approved a motion to further study this benefit. The Society's accountant and attorney indicated that this in no way impaired or conflicted with AMS Pension Plan.

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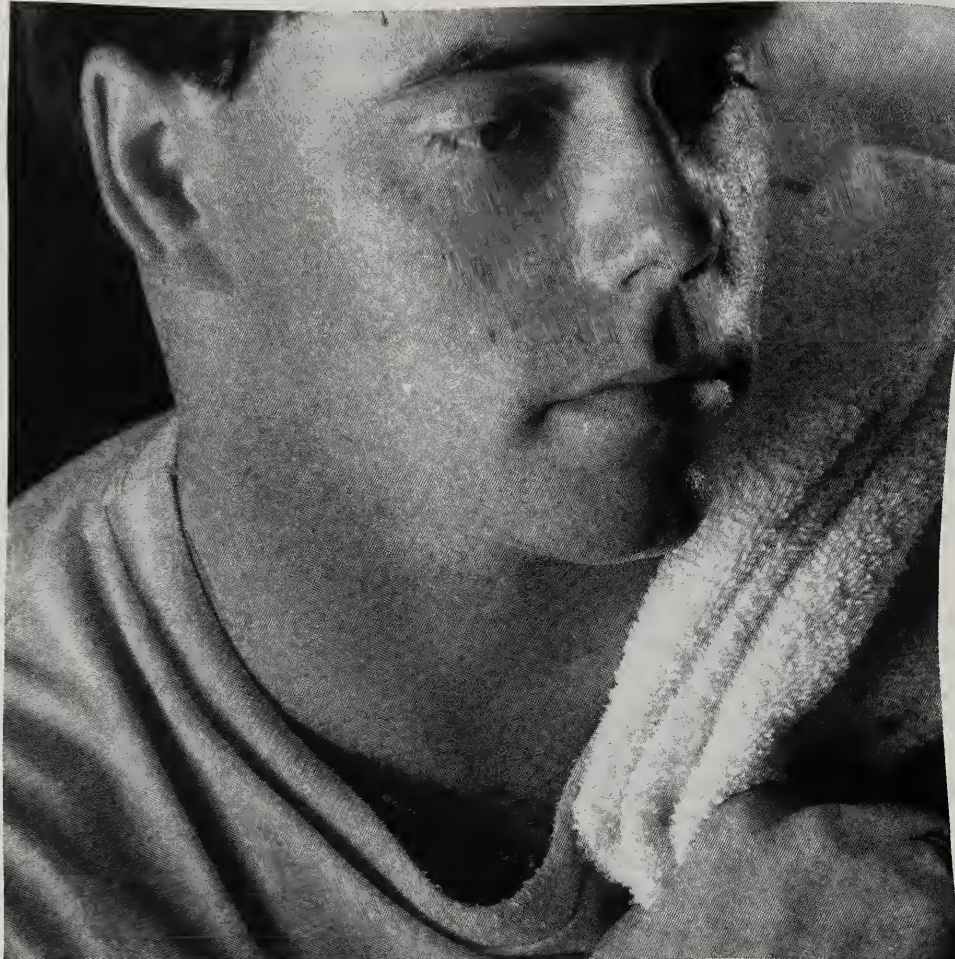


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Association**





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## Arkansas Department of Health

**M. Joycelyn Elders, M.D., Director** \_\_\_\_\_

The mission of the health department is to protect and improve the health of the people of Arkansas through assessment, policy development, and assurance of quality services. Fulfillment of this mission depends upon a sustained commitment to public health initiatives from both public and private sectors. The health department gratefully acknowledges the continued support of the medical society and its members in responding positively to the public health needs in Arkansas.

I am pleased to submit to you a report of highlights of the numerous activities that the Arkansas Department of Health (ADH) was involved in during 1991.

### *New Grants and Funding*

In calendar year 1991, two grants totaling \$610,000 from the Department of Health, State Health Building and Local Grant Trust Fund were approved for Pulaski County and Scott County. Pulaski County was awarded \$600,000 to match \$2.1 million in local funds to construct a three-story facility to house the Pulaski Central Unit. A women's clinic jointly operated by UAMS and the ADH staff will also be operated in the facility. Scott County was awarded \$10,000 to provide additional space for the clinic and redesign of existing space to accommodate computer equipment for better client service.

Through the AIDC ACEDP Program, Howard County was approved for Phase II of the application process to construct a new public health facility. The final grant award has not been determined by AIDC at this time.

Utilizing federal funds, the Arkansas Highway and Transportation Department contracted with the ADH to provide a public information campaign to promote 911 in counties which don't have a system. Currently, less than 50% of Arkansas' 75 counties have approved a 911 system.

Act 360 of the 1991 Arkansas General Assembly transferred the physician incentive program from the UAMS to the ADH. This act also increased payment incentives to \$50,000 maximum over five years.

Act 620 of 1991 Arkansas General Assembly established the Rural Health Services Revolving Fund. The purpose of this fund is to provide both financial and technical assistance to local communities in the stabilization of local health care systems. Communities interested in applying are required to have the following components: rural; be able to match the grant on a 50/50 basis; and be a county, local, commercial, or non-profit operation.

The Office of Minority Health was established to work with the Minority Health Task Force mandated

by the 1991 Arkansas General Assembly.

The ADH was designated as the State Office of Rural Health by the U. S. Department of Health and Human Services, Health Resources and Services Administration, and received a grant to provide the following: technical assistance to rural physicians on automated office operations; identification of federal and state rural health care programs and technical assistance to public and private entities participating in such programs; and up-to-date information to rural practitioners through newsletters and electronic bulletin boards.

The National Heart, Lung, and Blood Institute awarded a one-year grant to develop interventions aimed at reducing the morbidity and mortality associated with cerebrovascular disease. ADH's Strike Out Stroke initiative targeted 10 Arkansas counties with populations at highest risk from stroke as demonstrated by vital statistics and worked with community groups to develop educational interventions. Activities included health fairs, a Strike Out Stroke night at an Arkansas Travelers' game, and production of public service announcements.

The Agency for Toxic Substances and Disease Registry approved renewed funding for the third year of a cooperative agreement to provide education about toxic substances found in hazardous waste sites identified in Arkansas by the Environmental Protection Agency (EPA). Continuing education opportunities will be developed for physicians, nurses, and environmental health sanitarians who practice around the superfund sites.

The Agency for Toxic Substances and Disease Registry awarded a cooperative agreement to conduct an exposure study for dioxin among Jacksonville residents living within 1,300 yards of the incinerator of the Vertac Chemical Company.

The EPA awarded a grant to conduct a Comparative Risk and Strategic Planning Program to rate environmental health risks according to their adverse health effects. The EPA will use program results to utilize resources to correct or eliminate environmental health factors which present the greatest risk.

New Futures of Little Rock provided continuation funding to provide two positions for school health social workers. These positions provide public health/teen pregnancy expertise for two school teams.

The 1991 Arkansas General Assembly enacted legislation which increased the Public Water System (PWS) fees to support implementation of the federal Safe Drinking Water Act (SDWA) rules. Although the ADH received a grant from the EPA to enforce the SDWA, the money allocated does not support congressional amendments to the act made in 1986. The amendments mandate increased PWS chemical



testing and require water systems with surface water or surface water influenced sources to add filtration to the water treatment process. More public education, data reporting, and legal enforcement of SDWA rules are mandated as well. The increased fees enable ADH to begin hiring engineering and laboratory staff and purchase the necessary equipment and supplies to initiate implementation of the new rules.

The ADH was awarded continuation funding to provide expanded health services at Forest Heights Junior High School in Little Rock by the Johnson and Johnson Community Health Care Program. Started in October, 1990, the services are provided by a school nurse. Daily and periodic services include health screening, reproductive health counseling, mental health counseling, dental screening and referral, skin care, weight control programs, and immunizations.

The Henry J. Kaiser Family Foundation awarded a \$400,000 grant to the ADH to fund five community-based teen pregnancy prevention projects throughout the state. The grant award is accumulation of a process begun by the Arkansas Health Promotion Project in 1990, which included social reconnaissance to identify health issues and problems throughout the state; the establishment of a steering committee to provide guidance and direction; and the administration of a \$50,000 planning grant to establish a statewide coalition for health promotion. The Arkansas Health Promotion Project includes representatives from many organizations including the Arkansas Department of Human Services, the Winthrop Rockefeller Foundation, and the Arkansas Community Foundation on the steering committee. Additional consultation has been provided by the Office of the Governor and the Arkansas Advocates for Children and Families.

The ADH was awarded a five-year grant in the amount of \$782,000 by the Department of Health and Human Services to implement a Child Health Planning System in thirty-one counties. Counties were selected based on per capita income, minority populations, health care status, and number of health care providers and facilities to care adequately for the population. Through this grant, ADH will work to achieve a collaborative planning process for child health care delivery within two years, make the planning process a routine part of the operation and management of each local health unit in the state, clearly document the health care needs of counties involved and evolve strategies to address those needs.

Act 151 of the Arkansas General Assembly established the Arkansas Health Care Access Council with a membership representative of private and public providers, payors, academics, consumers, and professionals. The council is mandated to develop

plans for the improvement of rural health, provide aggressive outreach for immunizations of all children and create a medical home for all children under age 16 by the year 2000. Task forces have been established to reach each of these goals, and ADH has one or more representatives on each task force.

The Indigent Health Care Advisory Council awarded a \$520,000 grant to initiate expanded health services in Arkansas schools. Through a request for proposal process, nine schools - Turrell, Elaine, Helena, Forrest City, Marianna, Lake Village, Eudora, Pine Bluff, and Mills High School in Little Rock - were awarded funding. Funding criteria included the number of students participating in free or reduced school lunch programs, teen pregnancy rates, drop-out rates, suspension rates, child abuse rates, level of community support, and project evaluation. Services offered by each school, as determined by the school board, included EPSDT, treatment of minor illnesses and injuries, sports physicals, general physicals, immunizations, TB skin tests, monitoring of chronic conditions, wellness promotion, preventive health screening, reproductive health counseling and related services (contraceptives), and health education. The staff of expanded health services include public health nurses, clerks, health educators, and social workers.

The Women, Infants, and Children (WIC) Program released an invitation to bid for a single source infant formula rebate incentive. Ross Laboratories was awarded the single source contract and now provide rebates to the WIC Program. It is estimated the contract will provide \$40,000,000 in rebates to the WIC Program during the three-year period of the contract, which represents an increase of over \$1,000,000 in rebates for each contract year.

The installation of a statewide communication network for ADH administrative units were completed with the assistance of approximately \$1.7 million from the USDA Food and Nutrition Service. The network is utilized by WIC to record and transmit participant information and to issue vouchers for WIC foods. The network reduces paperwork and saves time in the WIC certification and voucher issuance process. It also allows the ADH to increase the number of clients who can be served by existing staff and provides up-to-date information. Establishment of this network has made it easier to integrate services to patients.

### *Safety and Disability Prevention*

Rules were promulgated to change regulations to allow semi-automatic defibrillation of patients by non-paramedic level Emergency Medical Technicians.

The Division of Emergency Medical Services



added a Medical Director to advise on medically-related issues.

The Division of Emergency Medical Services began training lay evaluators to assist in administering Emergency Medical Technician examinations.

Studies on Lyme Disease were initiated to determine which species of tick in Arkansas carry the causative spirochete *Borrelia burgdorferi* and which species of wildlife may be reservoirs of the disease. Blood samples have been taken from mice, rats, raccoons, opossums, and deer to determine if they have positive antibody titers which will be evidence that the disease is present in Arkansas. Ticks are also being collected and examined to determine if they harbor the causative organisms.

Human Rabies Vaccine continues to be available to treating physicians throughout the state as the need arises. Consultation on the necessity for treatment of exposed individuals and statistics on laboratory confirmed positive animal cases is also available. Direct fluorescent antibody testing of brain tissue from suspected animals is conducted daily free of charge.

The Head Injury Registry pilot project, begun in 1990, was completed in 1991. The pilot, conducted in a five-county area in northwest Arkansas, involved active surveillance methods. During 1992, the pilot project will be converted to a passive surveillance system and expanded to include 15 counties in western Arkansas. Other head injury prevention efforts initiated in the past year have included bicycle rodeos for children and demonstrations by competitive cyclists to encourage safety practices.

### *Environmental Health*

Indoor air quality activities increased with the addition of an epidemiologist and consultant industrial hygienist. Steps were taken to establish the Arkansas Indoor Air Quality Network. Staff taught a seminar on indoor air quality to agency sanitarians.

Paper mills responsible for contaminating rivers with dioxin are now required to fund sampling and testing of fish for dioxin. Signs were posted along bodies of water which were contaminated by effluent from paper mills and superfund sites warning against fishing.

Act 292 of the 1989 Arkansas General Assembly required that the director of ADH establish and administer quality standards for x-ray facilities conducting mammography. An advisory committee was created and developed an amendment to the State Board of Health's Rules and Regulations for Control of Sources of Ionizing Radiation which incorporates mammography standards. The standards will become effective on February 1, 1992, making Arkansas one of the first states to develop

mammography regulations.

Proposed regulations for various sources of non-ionizing radiation, including laser light shows and tanning beds and low-frequency electromagnetic fields are being drafted in response to concerns raised by public and professional organizations. Currently, laser light show inspections are performed as necessary and tanning salons are inspected as requested. Equipment to measure electromagnetic fields has been ordered and services will be provided on a limited basis.

### *Health Promotion and Disease Prevention*

The document, "Healthy Arkansans 2000: Arkansas Health Promotion and Disease Prevention Objectives," was developed and published during 1991, as a result of a two-year process to provide a state response to the nation's year 2000 health promotion and disease prevention objectives. Over 250 health professionals, representing public health interests in both the public and private sectors, served on 19 work groups to address 21 subject areas including prevention of major chronic illnesses, injuries, and infectious diseases. ADH is coordinating Healthy Arkansans 2000 objective development, implementation and evaluation.

The number of patients screened under the auspices of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Medicaid children up to 21 years of age grew to 55,400 during 1991, representing an almost 1400% increase from 1988. The large increase is attributed to OBRA '89, which has enabled ADH to perform a better job of assessment for problems.

The average number of women and children served per month by the WIC Program increased by more than 13% during 1991. The average monthly caseload is currently 65,361.

A media program designed to increase the number of pregnant women who seek and receive prenatal care was initiated as part of the Campaign for Healthier Babies. The media program has been implemented in three phases - awareness, education, and incentive. The unique sponsorship of the program represents a coalition of the Arkansas Department of Health, the Arkansas Department of Human Services, the Arkansas Chapter of the March of Dimes, the University Hospital's Department of Obstetrics and Gynecology High Risk Pregnancy Program, and the Arkansas Advocates for Children and Families. The Campaign for Healthier Babies, funded through a Healthy Futures grant from the Robert Wood Johnson Foundation, is a three-year statewide program to lower the infant mortality rate in Arkansas.

"Hold Out the Lifeline," a program to reduce



infant mortality in the south by encouraging early prenatal care through accessing the spiritual support, guidance, communication, and social infrastructure of the religious community was initiated jointly with the Arkansas Advocates for Children and Families. Hold Out the Lifeline is sponsored by the Southern Governor's Regional Project on Infant Mortality.

The March of Dimes program, "Babies and You," is being administered by ADH to reduce infant mortality through offering prenatal education in businesses. The program is flexible and can be customized to meet the needs of any size or type of business.

"Arkansas' Time Bomb," a campaign to reduce teen pregnancy, was initiated to provide information for teens, their parents, and professionals who can provide guidance and counseling. Channel 4, KARK-TV, in a cooperative effort with ADH, launched the year-long statewide media campaign to focus public attention on adolescent pregnancy and its associated problems and to increase public support for adolescent pregnancy prevention programs. The Emmy award-winning campaign has included news reports, public service announcements, and specials focusing on different aspects of the problem.

The Maternal Child Health (MCH) Information Line became operational in January, 1991, to provide statewide, confidential, toll-free information for teenagers, pregnant women, family members, and professionals. Established to assist individuals throughout Arkansas to access information on the availability of specific health-related services in their communities, services to date have included practitioner referrals and provision of educational material.

Beginning in October, 1991, all preschool children must be age-appropriately immunized to attend licensed day care centers in Arkansas. Compliance with this new requirement will be monitored by the Department of Human Services with on-site record audits at day care centers being conducted by ADH. Age appropriate immunizations include: 4 doses of DTP, Td, or DT; 3 doses of polio; 1 - 4 doses of Haemophilus influenzae type b (Hib); and, 1 measles/mumps/rubella vaccine by the time children reach two years of age.

A Health Fair at Southwest Mall in Little Rock, was held during National Immunization Awareness Week, September 21-28, 1991. Sponsored by the Governor's Health Care Access Council, the Department of Human Services and ADH, a total of 315 vaccines were administered with 157 doses given to pre-schoolers. Immunizations, blood pressure screenings, and vision screenings were offered at no charge. Other organizations participating in the Health Fair included Baptist Medical Center and Arkansas Children's Hospital.

The Arkansas Immunization Reporting System (AIRS) began sending letters to parents of children delinquent on their immunizations. Current age-appropriate immunization rates for two year old children is 60%. Overall rates have increased approximately 2% each month since the initiation of AIRS in May, 1991.

Second dose measles vaccine is being provided by ADH to seventh graders and college freshmen on a voluntary basis. Current budgetary restraints prohibit mandatory second dose of measles requirements for these targeted groups. When sufficient funds become available, the required second dose will be added to the existing public and private school (K - 12) and college/university immunizations laws.

The Parent-Infant Program was initiated to provide information regarding infant stimulation in the areas of play and communication for new parents and parents whose infants are at-risk for communication problems. ADH personnel continue to train child-care facility workers in the area of screening procedures for vision and hearing disorders with demonstrated results in pre-school children receiving quality screening services and vision and hearing problems being identified earlier.

The Health Resource Services Administration (HRSA) provided ADH with approximately \$276,000 to provide medical services to persons with HIV disease and AIDS. For the first time, persons living with HIV disease in Arkansas can receive laboratory testing, drug therapy, and in-home services. In-home services include IV drug therapy, personal care and assistance with household chores, transportation to and from physician and social service offices, and financial coverage for existing health insurance premiums.

Since May 1991, all ADH maternity patients have been screened for hepatitis B antibody. Those identified as being positive are tracked and their babies are immunized. ADH has also provided lab support, vaccine, and follow-up to patients presenting for delivery at private hospitals having no prenatal care for hepatitis B antibody. During 1991, ADH tested 5,058 women and confirmed 35 to be positive for hepatitis B antibody.

In July, 1991, ADH began offering Norplant, a new implantable hormonal contraceptive, to Medicaid and self-pay patients. The implant protects women from pregnancy for up to five years. To date, more than 300 patients have had Norplant inserted by ADH clinicians in 33 sites around the state.

In-home care services provided through county health units experienced a 28% increase in services provided during the previous year. Currently 7,500 patients receive care at home each day, under orders



from their physicians. About half of these were recovering from a serious illness and about half were frail or chronically ill and at-risk of institutionalization.

Since July, 1991, in-home care services offered by ADH have been available 365 days a year, twenty-four hours a day. This is accomplished through the use of a statewide communications system and on-call nursing personnel.

#### **AMS/ABA Task Force on Drug and Alcohol Abuse Marvin Leibovich, M.D., Chairman**

---

The Arkansas Medical Society and the Arkansas Bar Association have joined forces to combat the war on drugs. Our program is being patterned after an American Medical Association/American Bar Association initiative to bring a new perspective to the fight: a teaching approach which combines the skills and experiences of doctor/lawyer teams to educate our children about the dangers of drug and alcohol use before they get into trouble. Our targeted audience will include elementary and junior high school students. Programs are to be presented at public school during school hours.

Our medical society task force has met to discuss a possible program format. Mr. Ken LaMastus, AMS executive vice president, and I have met with the membership of the Arkansas Bar Associations' Task Force chaired by Mr. Rob Lawson of Little Rock, to develop an implementation schedule for our joint program. The teams will initially present their programs in the following counties: Craighead, Crittenden, Hot Spring, Jefferson, Malvern, Pulaski, Saline, Sebastian, Union, and Washington.

We will soon be calling on physicians in these counties to volunteer to serve on teams, and to arrange with educators for team visits to schools in order to provide practical and valid information about drug and alcohol use and to answer questions.

I want to especially thank the following members of the committee who have given freely of their time and who have expressed enthusiasm for this worthwhile endeavor: Drs. Gary Bevill, Larry Braden, Lisa Cosgrove, Byron Curtner, Bradley Diner, David Fried, William Jones, Laurie Lewis, Wendall Pahls, Patrick Savage, Steve Schoettle, Elicia Sinor, Janet Titus, and Virgil Wooten.

I also want to express my appreciation to our Society's immediate past president, Dr. William Jones, for bringing this concept to our state, and to our Society's current president, Dr. George Warren, for his support of the work of our task force.

#### **Report of the Executive Vice President Ken LaMastus, CAE**

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The entire health care industry is facing change at an ever increasing rate. The same holds true for the Arkansas Medical Society.

The Association ended December with a good year. We have been implementing the new Constitution and Bylaws that were approved in final form in April 1991. Some of the changes included adding the treasurer to the Executive Committee and placing tenure on members of the Council. The eight-year tenure, which is phased-in over a period of time, will begin affecting some Council members during annual session in April 1992.

We lost one valuable member of the Society's management staff last year. Peggy Pryor Cryer had been with us since our move from Fort Smith to Little Rock. She left to assume the position of chief staff person at the Arkansas State Medical Board. We wish her well.

Peggy was replaced by Kay Waldo. Kay was formerly vice president of One Bank of Little Rock. We are very happy to have Kay with us.

The Society ended the year in good financial shape. Our revenues exceeded expenses.

We also had a good year in the legislature. The biggest benefit to a large number of physicians was the passage of the Provider Tax which provides funding for Medicaid. This allows Medicaid to fix the fees to physicians to 80% of the Blue Cross Blue Shield UCR. This is the amount Blue Cross Blue Shield usually pays with the other 20% being the co-insurance. This is especially helpful to many of the physicians in areas where there is a large Medicaid population. We were successful in lowering the statute of limitations on minors.

The Arkansas Medical Society Building which is owned by a limited partnership, has faced some financial problems this year. These problems were caused by over-building of office space in the Little Rock area and a downturn in the economy. Rents have not increased as originally projected when the building was built. It is a possibility the Arkansas Medical Society may have an opportunity to buy the building. This project has consumed a considerable amount of time in discussion before the Council. We will probably have a resolution of the questions concerning the building early in 1992.

As a benefit to members, the Arkansas Medical Society is pursuing an Employee Benefit Trust arrangement to set up a self-insured health insurance plan. This involved the setting-up of the trust but also establishing a for-profit subsidiary that would market other insurance products to our members at a savings over what they can obtain from other agencies.

Some of the biggest concerns for physicians this



year have been the Clinical Laboratory Improvement Act (CLIA). The regulations were developed by the Health Care Financing Administration (HCFA). These regulations were totally unacceptable to the medical profession and resulted in over 100,000 letters being written to HCFA. The results were that the HCFA regulations are being redrafted and are to be reintroduced in 1992 with, hopefully, some more reasonable language.

This year also saw information released on the Resource Based Relative Value Scale which is to provide a method of payment for physicians under Medicare. It went into effect, at least partially, January 1, 1992. The end result is that about half of the physicians in Arkansas will be better off, but about half will have a reduced payment from Medicare. RBRVS is a question that will be debated and argued with changes made over the next few years.

There are some things in the regulations that have changed and many people are especially concerned about the lack of Medicare paying for interpretation of EKG's. It is anticipated that many insurance companies will go to the new RBRVS system of payment. In fact, Arkansas Blue Cross Blue Shield is all ready moving in that direction especially on the new evaluation and management codes.

A look into the near future seems to reveal that this country will have some insurance/medical care system reform. Most all medical societies as well as all physicians in the country are concerned as to what this so-called reform will mean. One thing is obvious—this reform is the number one issue facing the presidential candidates.

Physicians have proven that if enough of them get aggravated and involved they can make positive changes. These new reforms certainly will present new challenges for the physicians in this country. A question all of us have is are physicians willing to work together in a unified voice to see that these reforms are done in such a matter that will benefit people in this country and will give a fair and reasonable return to physicians for their labors.

## **Governmental Affairs Council** **Charles Rodgers, M.D., Chairman**

The absence of a state legislative session in 1992 has not deterred the amount of activity addressed by the AMS Governmental Affairs department. On the state level, the Society has been actively involved in regulatory activity concerning: medical waste, worker's compensation, Medicaid, perinatal proposals, and certified rural health clinics. The focus for the next few months will be on identifying and anticipating legislative issues for the 1993 Arkansas General Assembly.

### ***Federal Activities***

Federal mandates for 1992 created unprecedented changes in the operation of physician offices. The AMS has been engulfed in the process of responding to and monitoring regulations regarding new CPT coding; the RBRVS fee schedule; unique physician identification numbers (UPIN); Clinical Laboratory Improvement Act (CLIA) surveys and regulations; safe harbor/self-referral regulations; etc. Monitoring the various health care reform proposals currently being circulated in Congress by both Republicans and Democrats will dominate the remainder of 1992.

### ***MED-PAC Update***

Membership in our political action committee is improving but is still pitifully low. We are off to a good start in 1992 with 90 physicians and spouses contributing to MED-PAC, but this being an election year with May primaries, it's important that we raise sufficient funds early to support our friends and oppose our enemies. As evidenced by the continued intervention of government into the practice of medicine, never before has it been more important for physicians to invest their time and money in the political process.

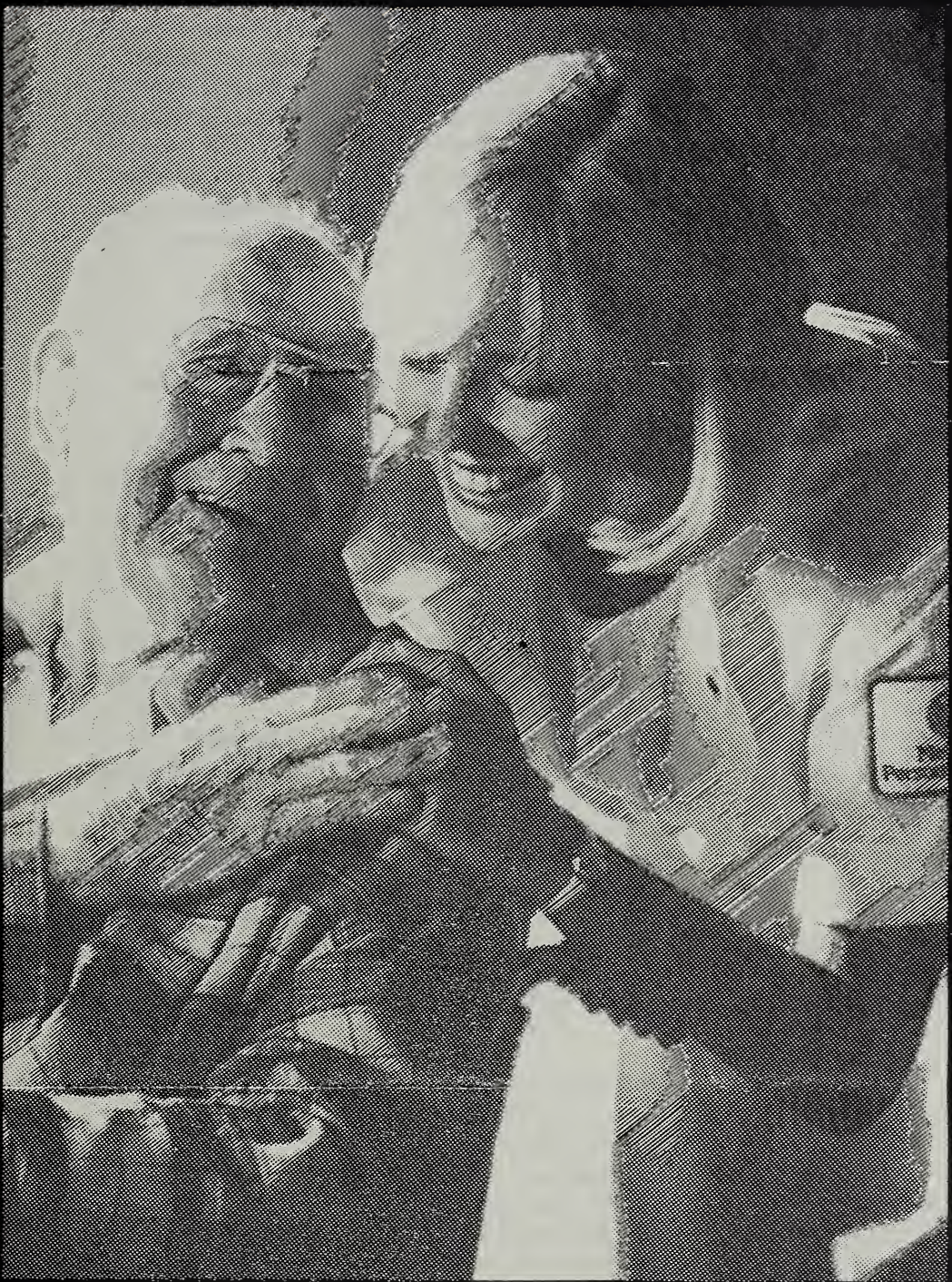


## **MED-PAC** **Arkansas Medical Society** **Political Action Committee**

MED-PAC is the political voice for the Arkansas medical community, and we must support political candidates who best represent our concerns. Please join us and become a part of the solution.



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**Arkansas Health Care Access Foundation, Inc.**  
**W. Ray Jouett, M.D., Chairman** \_\_\_\_\_

The United States is considered by many to be the richest country in the world; but even in this richest of all countries, not everyone can afford to pay for health care. Even though the vast majority of people in this country are employed, many cannot afford the cost of modern health care. In the state of Arkansas, it is estimated that 12% to 15% of the population have no health care insurance and many in this category cannot afford the cost of regular health care. Many indigent persons who are truly disabled and most persons over 65 years of age are covered by Medicaid and/or Medicare. In the remainder of the indigent population, health insurance is too costly and they have little or no other options for health care. The Arkansas Health Care Access Foundation, Inc. was established to help address this problem.

The Foundation, through its volunteers, helps provide free and reduced cost medical care to indigent persons in Arkansas who do not qualify for Medicaid or Medicare and who have no form of health insurance. Once certified as eligible through their local Department of Human Services office, clients have access to a statewide toll-free number where they can be referred to a volunteer physician (or other professional) to receive free (or at provider cost), non-emergency health care in their locale.

Arkansas Health Care Access Foundation, Inc. has been functioning for two and one-half years. It was begun in September, 1989, with guidance and support from the Arkansas Medical Society. Volunteering to participate in the program are a network of over 800 volunteer physicians and more than 600 other health care professional organizations, including dentists, pharmacies, hospitals, home health agencies and Arkansas State Health Department offices. More than 16,000 individuals have been certified for the services and over 3,500 have received donated care.

The population of Arkansas makes use of the Foundation's health care services for a variety of reasons and in a variety of ways. While the applicants are not representative of the general population of Arkansas, they are found in all parts of the state. Applicants are black and white, male and female, adolescent and adult and from rural and urban areas of the state. The applicants share certain commonalities: They are in need of health care, they are unable to pay for health care, and they are not covered by health insurance.

The Foundation continues to recruit volunteers statewide and to add more medical services. The Arkansas Public Health Association each year grants an award to a health-related Arkansas organization,

with some past recipients being The University of Arkansas Medical Center Newborn Transport Unit, Ronald McDonald House, and Arkansas AIDS Foundation. In April, 1991, The Arkansas Health Care Access Foundation, Inc. received the Grant Award. This \$500 award is being used to buy prescriptions for those patients who cannot afford to purchase their prescriptions at discount. Currently, the Foundation is working with a major pharmaceutical manufacturer, to help get certain prescriptions donated to the patient.

Information about the Arkansas Health Care Access Foundation is circulated through news releases, public service announcements on television, and radio and television talk shows, in which volunteer physicians and AHCAF employees have taken part. The Department of Human Services in each county, other health care organizations throughout Arkansas and by word of mouth from individuals who have accessed the service, continues to serve as the base from which most individuals enter this program.

Benefits to the users of this program are that the client has an entry into a needed, complex and expensive system. The providers themselves benefit from a simple, well monitored and administered program, with little paperwork, that allows them to provide care to those truly in need through an organized and equitable system. One final benefit to both the client and the Arkansas health system is the potential to minimize cost by early medical intervention.

Indications are that without this program the needs of the medically indigent are not being met. The number of eligible clients is expected to continue to grow. Demands on the state's public and private health care systems should also be expected to grow due, at least in part, to the Arkansas Medicaid program shortfalls. This innovative health care referral program is the only one of its kind in the state and only one of a very few in the nation. It is uniquely suited to the needs of Arkansas. The success of this program has depended upon the dedication of Arkansas physicians who care about the medical needs of the poor. They are to be commended for their continuing attention to this problem.

**Independence County Medical Society**  
**Russell P. Webster, M.D., President** \_\_\_\_\_

The Independence County Medical Society conducted its year end visit in November. At that time the following officers were elected: Dr. Russell P. Webster, president; Dr. Ron Simpson, vice president; Dr. E. J. Jones, secretary/treasurer; and Amy



Thalmueller, executive secretary. Delegates elected to the Arkansas Medical Society were Drs. Lloyd Bess and J. R. Baker, and Dr. William Waldrip as alternate delegate.

## Arkansas State Medical Board

### Peggy Pryor Cryer, Executive Secretary \_\_\_\_\_

The year 1991 was a year of great change within the Arkansas State Medical Board. On July 1st, after operating for 43 years in Harrisburg, Dr. Joe Verser resigned as secretary/treasurer and the office was moved to Little Rock. Peggy Pryor Cryer currently serves as executive secretary. An entirely new office staff was hired. The office has continued to operate with no break in any of its services. The new location is 2100 Riverfront Drive, Suite 200, and the facility is large enough to accommodate all meetings and hearings of the board.

In accordance with Ark. Code Ann. 17-93-301, two new positions were created on the board to add a representation for the Doctors of Osteopathy (D.O.) and an additional member-at-large position. The board currently has 13 voting members - 11 physicians, and two lay persons. Board members are as follows: Drs. W. Ray Jouett, chairman; Warren M. Douglas, vice chairman; Alonzo D. Williams, secretary; Asa A. Crow; James L. Garner; Jim E. Lytle; Linda A. McGhee; Rhys A. Williams; George F. Wynne; and James D. Zini, D. O. The current lay members of the board are John B. Currie Sr., treasurer, and Dewey Lantrip.

The summary of board proceedings for 1991 are as follows:

Notice and order of hearing issued	16
Violations of the Medical Practices Act	6
Suspension of license	3
Issued show cause	1
Surrender of licensure	1
Surrender of DEA	1
License denied	3
Individual cases addressed	115
Resident physicians licensed	4,275
Non-resident physicians licensed	2,669
Licensed by exam	94
Licensed by national boards	102
Licensed by reciprocity	129

In the change of any administration, procedural changes are sure to follow. One such change made by the board is in the issuance of temporary permits. At the September 19, 1991, board meeting, the board voted to eliminate the abuse of temporary permits. Temporary permits are now being issued only to

physicians whose applications have been completed and are ready to be presented to the board for licensure. This change, as well as others, will bring the State of Arkansas more in line with surrounding states.

Effective July 1, 1991, the Board of Physical Therapy separated itself from the Arkansas State Medical Board and formed their own office. Other health care professional boards currently being administered by this board and the total number licensed in 1991 are: occupational therapists - 348; respiratory care therapists - 180; and physician trained assistants - 38.

### *Current assets as of 6/30/91:*

Cash	\$412,803
Certificates of Deposit	550,827
Accrued interest	<u>6,880</u>
Total	\$970,510

### *Fixed assets at cost:*

Furniture, fixtures, equipment	\$37,314
Less depreciation	<u>19,804</u>
Net fixed assets	17,510

Total	\$988,020
-------	-----------

### *Liabilities:*

Accounts payable	\$36,095
Deferred income	29,325
Accrued payroll taxes	<u>581</u>
Total	\$66,001

Fund Balance	\$922,019
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Liabilities & fund balance	\$988,020
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## Medical Education Foundation for Arkansas

### W. Martin Eisele, M.D., President \_\_\_\_\_

The Medical Education Foundation for Arkansas receives \$5.00 in revenue for each full dues-paying member of the Arkansas Medical Society and a similar proportion for those who pay partial dues. This goes to fund the private non-profit corporation organized by the Arkansas Medical Society in 1959.

The MEFFA Board meets from time to time to discuss ways the Foundation can benefit UAMS. This assisting of medical education is the primary focus of the Foundation. Each year we use funds to pay for outside speakers for UAMS students.

The following is a list of those speakers the Foundation paid for either in-full or in-part in 1991:

Phillip G. Boysen, M.D., Professor of Anesthesiology and Medicine, University of Florida



Donald J. Donaldson, Ph.D., Department of Anatomy and Neurobiology, University of Tennessee

Magdalena Eisinger, Sloan Kettering Institute, New York

Lerner B. Hinshaw, Ph.D., Oklahoma Medical Research Foundation

Kaj H. Johansen, M.D., Professor of Surgery, University of Washington Affiliated Hospitals and Harborview Medical Center

Kenneth Ludmerer, M.D., Washington University

Dr. Jay Pettegrew, Department of Psychiatry and Neurology, University of Pittsburgh

Emmanuel Stein, M.D., Professor of Family Practice and Internal Medicine, Eastern Virginia Medical School

Dr. Rita Teele, Associate Professor of Radiology, Harvard School of Medicine, Boston Children's Hospital

Dr. William P. Weidanz, Professor and Chairman, Department of Microbiology and Immunology, University of Wisconsin Medical College

Dr. James H. Woods, Professor of Pharmacology, University of Michigan

Foundation funds are managed by the president and Ken LaMastus under policies established by the Foundation board. Each year the Foundation undergoes an audit by an independent CPA firm.

I would like to thank the other members of the MEFFA board for this year. They are Vice President Dr. Amail Chudy, Dr. Ray Jouett and Dr. Gerald Stolz. Ex-officio members are the president of the Arkansas Medical Society, president-elect, immediate past president, and the dean of UAMS.

Located in this issue of *The Journal* is a position paper established that explains the functions and organization of MEFFA. I would like to thank the Position Papers Committee for assisting in publicizing to the members the important role of the Foundation.



## Medical Services Review Committee

**John Crenshaw, M.D., Chairman**

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The Medical Services Review Committee continues to assist in evaluating selective cases for Arkansas Blue Cross and Blue Shield and Medicare. These physicians are selected by the Council on recommendations from the various specialty groups.

Currently, 21 physicians serve on MSRC as representatives of their specialty, and the Executive Committee for the Arkansas Medical Society also serves with this group. In addition, there are none physicians who serve on the sub-committee as subspecialties and are contacted when specific problems involving their sub-specialty occur.

This committee continues to serve a valuable function, benefitting the patients covered by Medicare and Arkansas Blue Cross Blue Shield. The physicians who assist in their care are also benefitting. The changing of federal regulations is likely to increase the difficulty in proper adjudication.

Dr. Robert Benafield has retired as medical director for Arkansas Blue Cross Blue Shield. His years of leadership were recently recognized during a MSRC meeting. The MSRC looks forward to working with Dr. William White in his new position.

## Medical Student Section

**Katherine Henry, President**

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The Arkansas Medical Society began right away in the fall of 1991 with the hosting of activities during orientation week for incoming freshmen. The welcome reception was held at the Hilton Inn and was attended by 300 freshmen students, spouses, faculty, and AMS representatives.

Studies began promptly but were relieved at the close of the second week with the annual AMS sponsored freshman/sophomore picnic. Two hundred and fifty students partook of barbecue, volleyball, and the sun at Maumelle Park for a Friday afternoon and evening.

Elections were held at the next meeting with new officers stepping in for the 1991-92 school year. Officers elected were: Katherine Henry, president; Elise Fortin, vice president; Kimberly Garner, secretary/treasurer; Janet Hodge, AMS delegate; and Yvette Randle, AMS alternate delegate.

Dr. Joseph Beck, chairman of the AMS Task Force on AIDS, presented AIDS issues pertaining to health care workers. Insurance, mandatory testing, and the most recent developments concerning treatment were all considered.

Katherine Henry, Elise Fortin, and Kimberly Garner attended the national AMA-MSS interim meeting in Las Vegas. The Arkansas Medical Society,



The Upjohn Company, and Marion Laboratories sponsored the trip. The students helped to formulate and vote on resolutions that were submitted by the AMA. The December convention created an atmosphere in which there was much to learn. Blackjack was the favorite.

## **Pension Plan Trustees**

**Joe H. Stallings Jr., M.D., Chairman** \_\_\_\_\_

The AMS Pension Plan Trustees received by mail a report on pension plan earnings through the third quarter. At that time the earnings were at 12.43%, annualized. We are hoping the year-end report will be even better.

There have been no changes in the pension plan since last year's report. The trustees have not had a formal meeting. However, they have received reports from Worthen Bank and were polled concerning the investment strategy for the funds of the pension plan. The vote was to follow the middle-of-the-road investment strategies. The same has been done in previous years. This strategy involves investment in some bonds and some stocks with a minimal risk.

The plan, as in the past, is a defined contribution plan. This means that if the Medical Society makes its monthly contributions to the pension plan there is no way it can become in arrears from underfunding.

At retirement any employee is due the amount allocated in his name. This is different from defined benefits in which contributions must be made to arrive at some fixed level at retirement.

In summation, I can say that there have been no changes in the Medical Society's Employee Pension Plan Trust during the year.

I would like to thank the other trustees. They are Drs. Thomas Hollis, James Pappas, and James Kolb.

## **Physicians' Health Committee**

**Joe L. Martindale, M.D., Chairman** \_\_\_\_\_

The AMS Physicians' Health Committee is actively monitoring 49 in-state physicians and six physicians who have come to us from other states. During 1991, we sent 12 physicians to treatment and investigated three who did not need treatment.

We have three Arkansas physicians in Alcoholics Anonymous groups around the state that meet weekly and then once a month in Little Rock. The monthly meeting includes Alanon (the spouses' group). The American Society of Addiction Medicine also meets monthly. This year we have formed a Caduceus Club group which meets weekly in Little Rock and have increased our support to families

whose spouses receive treatment.

We are currently receiving funding from the Arkansas State Medical Board, the Arkansas Medical Society, St. Paul Insurance Company, and State Volunteer Mutual Insurance Company. We greatly appreciate this support, however, this limited budget does not allow us to participate with many of the national groups. Participation with these groups would help us to improve our program and enable us to reach more doctors.

Other activities of the committee in which I personally participated included attending four risk management seminars in 1991, two of which were sponsored by St. Paul and two sponsored by State Volunteer, and assisted a major hospital in Little Rock in setting up a Physician's Health Group (hopefully this group will become a model for other hospitals around the state). Dr. Don Browning, assistant director of the Committee, also conducted an educational seminar at the Conway County Hospital.

The Physicians' Health Committee greatly appreciates the support of the Arkansas Medical Society, the AMS Council, the Arkansas State Medical Board, Mr. Ken LaMastus and his office personnel. Without your help we could not survive.

## **Physicians' Health Committee Budget**

<i>Income</i>	\$45,000
<i>Expenses</i>	
Medical Director	35,000
Computer Software	200
Office Equipment	300
Supplies & Postage	500
Telephone/Answering Service	2,000
Travel	5,000
Miscellaneous Expenses	500
Total	\$43,500

## **Committee on Position Papers**

**James Kolb Jr., M.D., Chairman** \_\_\_\_\_

The Committee on Position Papers developed and sent to the Council one paper this year. It was on the Medical Education Foundation for Arkansas.

The paper was developed to publicize in *The Journal* information about what MEFFA is and how it functions. It does appear in this issue of the magazine and is to be approved by the House of Delegates.

I would like to personally thank the other people who served on the committee. They are Drs. Jim English, Lee A. Forestiere, J. David Busby, George Warren, Payton Kolb, Roger Cagle, Lloyd Langston, Paul Cornell, and David Barclay.



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## **Pulaski County Medical Society**

### **Ashley S. Ross, M.D., President**

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The Pulaski County Medical Society (Eighth Councilor District) was involved in a number of activities in 1991. Some of the more significant ones are explained below.

The Society held two meetings during the year. One dealing with workers' compensation regulations and one dealing with medical/political issues and featured U. S. Senate candidate David Busby, M.D.

A letter of endorsement was written on behalf of the Jefferson Comprehensive Care System, a nonprofit federally funded clinic, to assist them in their application for continued funding.

Letters were sent to all state senators and representatives from Pulaski County urging them to vote for a mandatory safety belt law and against a repeal of the motorcycle helmet law.

Financial contributions were made to Med-Camps of Arkansas and to the Pulaski County Medical Society Auxiliary to help print the booklet "For Your Information," a resource guide for teens.

A \$5,400.00 scholarship was awarded by the Society to a freshman at the University of Arkansas College of Medicine.

Additionally, the Society continued its administrative support of the Senior Physicians of Arkansas organization.

## **University of Arkansas College of Medicine**

### **I. Dodd Wilson, M.D., Dean**

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The College of Medicine had a good year in 1991. The new chairs and division directors named in 1990 were very active in recruitment of faculty for their departments (biochemistry and molecular biology, anesthesiology) and divisions (oncology, toxicology, and nephrology). Growth continued in the departments of psychiatry, pediatrics, pathology, surgery, ophthalmology, anatomy, and physiology.

Notable examples of senior faculty added or recruited in 1991 included: Alan Elbein, Ph.D., Professor and Chairman, Department of Biochemistry and Molecular Biology; Hugo Jasin, M.D., Professor of Medicine and Director, Division of Rheumatology; Patrick Walker, M.D., Professor of Pathology; Kenneth Wu, M.D., Professor of Medicine and Co-Director, Center for Vascular Biology; Raeford E. Brown, Jr., M.D., Associate Professor of Anesthesiology, Chief of Pediatrics Division; Sam Smith, M.D., Associate Professor of Surgery and Director, Division of Pediatric Surgery.

Several important recruiting efforts occur this year. Because Drs. Stevenson Flanigan and Ryland Mundie will step down in the Department of Neuro-

surgery and the Division of Emergency Medicine, searches for their replacements are underway. Division directors will be identified for two new divisions, radiation oncology and a combined program in health services research, biometry and epidemiology. The search for a chairman in the Department of Microbiology and Immunology will be greatly aided by excellent space on the fifth floor of our new Biomedical Research Building.

During 1991, Lee Lee Doyle, Ph.D., accepted a position of associate dean of continuing medical education. She will strengthen programs aimed at helping physicians continue their learning, using the new technology available for such purposes. Tim O'Brien, Ph.D., became associate dean for research and Mrs. Linda Williams accepted the position as director of admissions.

Effective education of physicians for Arkansas remains the primary focus of the College of Medicine. This requires at least the following four components:

1. Recruit and select matriculants with qualities essential for the skillful and ethical practice of medicine. This task has been made both easier and more difficult because applicants from Arkansas have increased over four years from 221 to almost 400. Even though the overall academic qualifications of entering classes have not changed greatly, performance in medical school is better and attrition is decreasing. The faculty voted to reinstitute prematriculation college course requirements in order to improve preparation of our matriculants for medical school.
2. A strong educational program. We have used the principles of continuous quality improvement of our courses with positive results. This year, a new clerkship in family and community medicine has been well received. Student morale is the highest it has been in five years. Our students improved their performance dramatically on Part I of the National Board test. The faculty is considering methods to increase problem-based learning, to develop in-depth review of courses, to test clinical skills in senior medical students, and to provide opportunities for academic enrichment. Our goal is to develop excellence in the spectrum of medical education, from college preparation through medical school and residency and into continuing medical education.
3. Instill desire and teach skills essential for continuing self-education. All medical schools have difficulty with this goal. One approach that UAMS is using is to increase the use of databases, computers and videodisc technology in



education, using that the hypothesis that each physician will have easy access through technology to the equivalent of a library of information in their homes and offices.

4. Interest students in disciplines such as family practice where shortages exist in Arkansas. During the past two years we began our family medicine clerkship, and a student-run family medicine interest group, increased participation in the rural preceptorship program and drafted successful legislation to increase incentives to practice in rural communities. UAMS has an outstanding record of educating family physicians and we plan to do even better.

The Liaison Committee on Medical Education conducted its accreditation visit in October, 1991. Prior to the visit, our faculty developed a database and conducted a self-study to identify strengths and weaknesses, as well as our future challenges. Although we have not received final word on the visit, we hope to be awarded full accreditation for the maximal seven-year period.

Extramural grants and contracts awarded to the College of Medicine increased from \$14,179,013 on June 30, 1990, to \$16,333,447 on June 30, 1991. Research funding at the McClellan Memorial Veterans Administration Medical Center was \$3,700,000 for 1990-91, up from \$2,837,526 the previous year. A highlight for 1991 was the acquisition of two center grants by Dr. Richard Smith and his research group. Both Dr. Shirley Gilmore and Dr. Edgar Garcia-Rill were chosen chairmen of NIH study sections, a real honor for UAMS. Construction began on major research buildings on the UAMS and Arkansas Children's Hospital campuses. Research space is an important commodity that will allow expansion of our programs through recruitment.

Many of our faculty have accomplishments of which we should be proud. A few stand out. Dr. John Redman is president-elect of the Southern Medical Association. Dr. James Suen was named Arkansas Citizen of the Year and Dr. Joe Bates was inducted into the Association of American Physicians. Finally, Dr. Bob Barnes was president of the International Society for Cardiovascular Surgery.

Other progress includes:

- A new anatomy education building has been funded and is being planned.
- Clinical programs are growing and improving. We are especially proud of the progress in the cancer, transplant, and trauma programs.
- The planning for the Harvey and Bernice Jones

Eye Institute has been completed and construction will soon begin.

- With the promise of a bridge between the University and VA Hospitals, greater emphasis will be placed on the sharing of programs.

The college deeply appreciates the support of the AMA-ERF, the Medical Society Auxiliary, and the Medical Education Foundation for Arkansas (MEFFA). The AMA-ERF scholarship endowment funds continue to grow. This year, five \$1,000 scholarships were awarded from the income from the AMA-ERF funds. The undesignated contributions from AMA-ERF were used by the curriculum committee for educational purposes. MEFFA funds supported 10 lectureships and two new educational programs for medical student education.

The College of Medicine is doing well. Our intention is to meet the needs of the citizens of Arkansas, our students, and the physicians of the state, whose support we appreciate.

### **Young Physicians' Committee**

**David Harshfield, M.D., Chairman**

The recent Young Physicians' Section (YPS) meeting of the American Medical Association which met in Las Vegas was one of the most productive we have had to date. Although all of the previous meetings I have attended have been well organized, educational, and of great benefit to those of us in attendance, to me personally there was a sense of apprenticeship in regards to most of our activities. The YPS was originally established as a recruitment incentive by allowing young physicians to have their own section. In addition to enhancing the membership of the AMA, it also provided a training ground for us to learn parliamentary procedures as well as increase our potential effectiveness in health care reform. The YPS has been an enormous success as almost 40% of the members of the AMA are now under the age of 40 or have been in practice less than five years (YPS requirements). What has not been a complete success in my opinion, at least until this last meeting, was the presentation of meaningful legislation from our section to the "big" House of Delegates. In this last meeting, we had heated confrontational exchange over our resolutions and, at the end of the meeting, we all sensed a new feeling. We were no longer a collection of journeymen or apprentices training ourselves in the art of political medicine with almost implicit rules not to rock the boat. It is apparent to us that the changes under current consideration will have the greatest impact on our practices.



Most of the older physicians are doing their best to maintain our health care system as they perceive it should be, however, many of those individuals will be retired before any of these changes are implemented. Although we are not as experienced in the ways of political medicine as our elders, we must have our feelings and ideas not only heard but supported by the AMA. Remember, professionals built the Titanic, amateurs the Ark.

One of the basic reasons the YPS was more or less a rubber stamp of the establishment of the AMA relates to our early beginnings. The YPS was born when a few aggressive young AMA members approached their elders and requested formation of their own group. They explained that this would be a boom to AMA recruitment and provide a training ground for future politically active physicians. As the YPS rapidly grew, we began to elect our governing council members and those individuals had aspirations on mainstreaming into higher offices in the established AMA. I am not being critical of our council members because their chances of mainstreaming into high offices of the AMA was based on how they were perceived by the older body. By recruiting members to the YPS, training those members how to become politically active (but not too active), the YPS council members improved their chances of obtaining higher office. During the early years of the YPS, approximately one-half of the members at each meeting would be brand new and inexperienced, therefore diluting the effectiveness of established members. As a higher percentage of us have been members now for several years, we have become more organized and are now aware of our responsibility, not just to the YPS, but to the future of the practice of medicine. We can no longer be a mere rubber stamp to AMA policies, we must make our feelings known by way of resolutions to the House of Delegates. It has only been in the last year that we have convinced the AMA House of Delegates to push legislation to have young physicians paid on the same level as older, more established physicians. The government has always paid a beginning physician only 80% of what they reimburse a physician who has been in practice with established fees. Only by our insistence and persistence have we persuaded the AMA to support the YPS position on equal pay regardless of age or practice experience (HR ???).

Several issues at this last caucus were debated in a highly emotional but inspiring manner. At the end of our resolution committee debates, we all felt a sense of unification and purpose. No longer did we have all of the controversial resolutions conveniently "referred for further review." We debated the issues, voted whether they should be policy of the YPS and, if so, sent them to the House of Delegates for im-

mediate consideration. There was almost a sense of urgency about the proceedings. I do not want to portray the YPS as becoming militant or in any way opposed to the mainstream policies of the AMA. On the contrary, we are an integral part of this body and understand that only through unification of all physicians, regardless of age, can we have the influence we need to affect acceptable changes in our health care system. I do feel, however, that young physicians are beginning to realize that no matter how busy we are in our practices, we must take time to participate in the development of the future of medicine. Our ideals, when properly organized and democratically passed onto the major House of Delegates, are no less important than those ideas of any other faction of the AMA.

The last few YPS meetings in the state of Arkansas were not well supported. Many people would agree over the phone to become active and to attend meetings, however when the meeting day arrived, they were too busy to attend. It surprises me that any physician would ever allow decisions to be made for them without at least their prior knowledge and approval. By not participating in the politics of medicine, we are allowing just that. Our profession is being changed to the benefit of the legislators, attorneys, and other self-interest groups who make the time to influence current reforms. There is no doubt that at some point in time it will occur to most physicians that they must become active, however, we are fast approaching the point after which it will no longer matter.

The following sections of this report is an overview from speakers at the YPS interim 1991 meeting representing many factions of health care reform. Most of the itemized proposed changes I will review come from ideas the republicans are proposing President Bush adopt as his strategy for health care reform going into this election year.

After attending the recent interim meeting of the AMA, many new concepts were espoused as means of addressing our health care crisis. Instead of completely dismantling our system, which would occur if we go to a national health insurance program, we might be better served by making appropriate changes, but maintaining the infrastructure of our present system.

This concept is based not only on changes needed in our health care system, but addresses aspects of this dilemma which also must be solved if any long-term success is to be achieved. The point is the problem cannot be solved solely by physicians, legislators, lawyers, or even patients. It will take input from all parties. The following are essential points that must be considered if the entire issue of health care in America is to be addressed successfully.



## *No Consensus*

Because there is a lack of consensus from all pertinent parties as to what sort of health care system we want or need (two entirely different concepts), we must arrange forums to hear all opinions. There are only two industrialized countries on earth, South Africa and United States, that do not provide at least some level of health care for all of their citizens. Because of growing problems with the privatized U. S. health care system, Americans have been looking at other systems in an attempt to gain insight into possible solutions. It is interesting to note that other countries are now looking to the United States' system for a model they could emulate to restructure their collapsing systems. Why do we want to change our system (even with all its current difficulties) to mimic one of the other systems — none of which are the panacea some opinionated advocates would have us believe? Instead, we have a great opportunity to make the necessary adjustments for our system to provide the best health care in the world.

There are two basic concepts to solving our health care problems in the United States. One faction believes we should totally scrap the existing system and replace it with a single-payor, National Health Insurance. The other approach would be to address and correct the major problems, but work within the framework of our existing system.

There are attractive aspects of National Health Insurance (single-payor concept), but we might sacrifice the positive aspects of our unique privatized health care system.

We need a consensus, and to arrive at a consensus, we need a forum in our states and communities. These forums should contain not only doctors, nurses, health care workers, lawyers, legislators, and hospital administrators, but also our patients. Early reports from trial forums with all of these representatives reveal that a trend of common "wants" and "needs" is becoming apparent. It may take a while before we reach a consensus on the exact method of attacking the health care issue, but in the meantime, we are accomplishing an education of all parties. With continued discussion and action, we will achieve our goal: birth of a system that provides the best possible access and level of care to all Americans and dissemination of these strategies to all countries of the world. We need to solve our own country's health care problems first, but we should not be so short-sighted that we forget the developing world economy and our leadership role in the future of this planet.

## *Health Care Form Standardization*

It is estimated that up to 15% of total health care dollars could be saved if everyone utilized a single,

standard form with which to bill for their services. The major reason National Health Insurance has been advocated is the potential savings in administrative costs. A universal billing form incorporated into our present system could accomplish the same goal.

## *The Under and Uninsured - Estimated at Greater Than \$40 Million*

Improve access to medical care by incorporating managed health care plans similar to those in Hawaii and Arizona, which have been successful in providing a basic form of health care to the uninsured. Also, there has been talk of decentralization of Medicare funding and giving the money to each state to take care of its indigent or uninsured patients through existing community health agencies.

## *Small Business (Self-insured) Reform*

- A. Require insurance companies to provide a more basic health plan (not the expensive top-of-the-line policies now forced on small business owners). This could reduce insurance costs as much as 33% of those who self-insure, and it would reduce the impact on small businesses for employee health coverage.
- B. Prevent insurance companies from "cherry picking" — a practice whereby they provide insurance to low-risk businesses but reject coverage to businesses if an employee has contracted an undesirable (costly) disease (AIDS, cancer, renal failure with dialysis, etc.)
- C. Challenge the inequity of large businesses being give a 100% tax deduction on insurance for their employees, while small businesses are allowed only a 25% tax deduction.

## *Rural Health Incentives*

Provide matching funds for medical school education grants for "hometown" students. This will not only provide funding for a medical education for students living in rural America, but it will ensure that, in exchange for their degree, they will return to their hometown to practice.

## *Children and Health Care*

Further decentralize and give the state (Medicaid) more authority than the federal government (Medicare) to tailor the individual needs of each state to care for its children and indigent patients.

## *Medical Liability Reform*

- A. No comprehensive method of health care reform — and thus no truly successful future program — will endure without addressing medical liability reform. There must be limits set on the rates lawyers can charge in tort cases and ceilings set



on awards not involving personal injury. We must limit liability in the areas of drugs and devices. Consumer "protection" has resulted in significant increases in the costs to patients for drugs and investigational devices.

- B. From a physician's standpoint, a "successful approach" at liability reform must address not only self-serving "physician" aspects (malpractice premiums, physicians' fees, etc.) but the entire issue, including liability related to hospitals, drug costs, FDA allowed devices, etc.

It has been shown time and time again that those things that are successful are those that best approximate "real life." Any proposal that does not address all issues raised by society will be only a temporary fix. The quick return, short-term mentality of our corporate society must be tempered with a rational, more patient, long-term approach.

As the situation worsens, we will finally hear all factions of the problem. Not until we establish the major issues that need to be addressed will we be able to piece together a plan for reform. Before this plan can be put to the American people for their approval, we must make the necessary adjustments to our health care system to ensure its long-term success. History has proven that when presented with the facts, the American public makes good decisions. Ultimately the American public will make the decision — whether directly, through referendum, or indirectly, through their elected officials. We must be sure that we are allowed our fair level of input into the final solution.

The AMA, through our state and local medical societies, gained considerable credibility with legislators last year, and we now have a great opportunity to favorably influence the reform movement. One thing is certain, the final solution will be based on what is best for society — not on what is best for physicians (or any single interest group for that matter).

As physicians, our profession had been entrusted with the responsibility for society's health care. The current system is unacceptable to society and we have received the blame — rightly or wrongly. We still have the capability to correct these problems, but it will take effort and input from all of us. We can become the most powerful lobby in the United States if we unify.

There will be no acceptable excuses if, because we don't have the time to participate in these reforms, we all end up as government employees, working in an underfunded, bureaucratically-managed health care system. Then we will have plenty of time to think about our decision not to get involved.

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**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

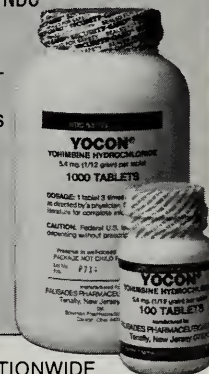
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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# AMS Newsmakers

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**Dr. Nancy J. Astle**, a Hot Springs dermatologist, has been appointed to the courtesy staff of St. Joseph's Regional Health Center in Hot Springs.

**Dr. Robert W. Barnes**, professor and chairman of the Department of General Surgery at UAMS, has been listed in "The Best Doctors in America."

**Dr. Anthony R. Burton**, a Fayetteville general surgeon, became a fellow in the American College of Surgeons

**Dr. Randall E. Cole**, a Rogers ophthalmologist, was selected and featured in the "Operative Profile" of *Ocular Surgery News*, one of the leading ophthalmic publications worldwide.

**Dr. Martin Eisele**, a Hot Springs general surgeon, was named to the board of directors of the Hot Springs Area Community Foundation.

**Dr. Robert Elliott**, a Searcy radiologist, was recently installed as the new president of the board of the Arkansas Division of the American Cancer Society.

**Dr. Howard R. Harris**, Dumas family physician, was reappointed to the Arkansas State Board of Health by Governor Bill Clinton. His term will expire December 31, 1995.

The **Independence County Medical Society** recently elected county officers for 1992. They are: Russell P. Webster, M.D., president; Ron Simpson, M.D., vice president; E.J. Jones, M.D., secretary/treasurer; Lloyd Bess, M.D., AMS delegate; J.R. Baker, M.D., AMS delegate; and, William Waldrip, M.D., AMS alternate delegate.

The **Ouachita County Medical Society** recently elected county officers for 1992. They are: R.H. Nunnally, M.D., president; Val Shrestha, M.D., vice president; Jerry Kendall, M.D., secretary/treasurer; and, Bill Dedman, M.D., AMS delegate.

**Dr. John Park**, a Fayetteville orthopaedic surgeon, was selected as the Arkansas delegate to the Council of Delegates of the American Orthopaedic Society for Sports Medicine and has also been appointed to the Arkansas Governor's Council on Physical Fitness.

**Dr. Kerry F. Pennington**, a Warren family physician, has been elected to the board of directors of Warren Bank & Trust.

**Dr. James A. Tanner**, a Little Rock OB/GYN, has been elected chairman of the Arkansas Section of the American College of Obstetricians and Gynecologists and will serve a three-year term.

**Dr. Douglas A. Treptow**, a Rogers general surgeon, became a fellow in the American College of Surgeons

**Dr. Mitchell Young**, a Texarkana general surgeon, has been named 1992 chief of staff at St. Michael Hospital of Texarkana and also will serve on the hospital's board of directors.

Brett Christoffersen, of North Little Rock, has been named the recipient of the 1991-92 **Northeast Arkansas Internal Medicine Clinic of Jonesboro Scholarship**. The scholarship was presented recently to Mr. Christoffersen at the College of Medicine's Parents Day at UAMS. This annual award pays full tuition and was presented to Mr. Christoffersen on the basis of his outstanding academic performance while attending Arkansas State University. The primary purpose of the scholarship is to encourage the brightest students in Arkansas to remain in-state to complete their medical education.

The University of Arkansas College of Medicine has announced the recipients of the 1991-92 Arkansas Medical Society Auxiliary **AMA-ERF Scholarships**. The scholarships are made possible by the county chapters of the Arkansas Medical Society Auxiliary. The county chapters contribute funds each year to the Auxiliary's AMA-ERF scholarship fund for medical students. The scholarships are awarded annually to medical students who demonstrate outstanding academic achievement and possess the humanitarian skills to become caring and compassionate physicians. The recipients are: Michael Higginbotham, Russellville; Teresa Cisneros, Benton/Hot Springs; Cynthia Willingham, Pine Bluff; and, Trina Swygert, Pine Bluff.

Jimmie Stewart and Jason Smith, senior medical students at the University of Arkansas College of Medicine, have been named recipients of the 1991-92 **Ilse F. Oates Scholarship**. The scholarship is



awarded to senior medical students on the basis of "good clinical capabilities, good academic standing, and good moral character." Funds for the Ilse F. Oates Scholarship Fund are made possible by the county chapters of the Arkansas Medical Society Auxiliary.

Barry Hendrix, a freshman medical student at the University of Arkansas College of Medicine, has been named the recipient of the **Pulaski County Medical Society Scholarship** for 1991-92. The Pulaski County Medical Society provides an annual scholarship to an outstanding first year medical student who is a permanent resident of Pulaski County. The scholarship is given to recognize outstanding academic achievement and financial need.

# New Members

## BENTON COUNTY

**McCollum, William E.**, Family Practice, Rogers. Born, March 7, 1956. Medical education, UAMS, 1983. Internship, University of Oklahoma School of Medicine, Tulsa, 1986. Practice experience, 5 years. Board certified.

## JEFFERSON COUNTY

**Hulsey, Matthew D.**, Family Practice, Pine Bluff. Born, May 21, 1961, Ironton, MO. Medical education, University of Health Sciences, College of Osteopathic Medicine, Kansas City, MO, 1988. Internship, Charles Still Osteopathic Hospital, Jefferson City, MO, 1989. Residency, AHEC, Pine Bluff, 1991. Practice experience, 1 year. Board certified.

## PULASKI COUNTY

**Thomsen-Hall, Kathleen A.**, Psychiatry, North Little Rock. Born, March 10, 1955, Denver, CO. Medical education, Loma Linda University, Loma Linda, CA, 1975. Internship/residency, UAMS, 1983. Practice experience, 8 years. Board certified.

## RESIDENT PHYSICIANS

**Lile, Scott A.**, Radiology, Maumelle. Born July 20, 1962, San Antonio, TX. Medical education, Vanderbilt University School of Medicine, Nashville, TN, 1984. Internship, Vanderbilt. Residency, UAMS.

**Thorn Jr., Garland M.**, Family Medicine, Little Rock. Born, December 30, 1959, Little Rock. Medical education, UAMS, 1990. Internship, University of Oklahoma, Tulsa. Residency, MUSC-Anderson Memorial Hospital, Anderson, SC.

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# Medicine in the News

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## Health Care Access Foundation Update

As of February 1992, the Arkansas Health Care Access Foundation has provided free medical services to 3,522 medically indigent persons.

The program has 1,461 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## American Heart Association Develops Cardiovascular Cabinet

The American Heart Association, Arkansas Affiliate, Inc., recently announced the development of a Cardiovascular Cabinet. The Cardiovascular Cabinet will be a group of high profile Arkansans working to raise restricted research funds. These funds will help close a critical heart research gap in Arkansas.

The Cabinet, led by Representative Mark Pryor, will recruit high profile Arkansans to help solicit monies to fund American Heart Association research grants to be conducted in the state. The grant will be named in honor of Rep. Pryor's father, U.S. Senator David Pryor, who suffered a heart attack in April of 1990. Senator Pryor's recognition and actions of the early warning of signals of a heart attack are credited for saving his life.

The American Heart Association, Arkansas Affiliate, Inc., is currently funding seven cardiovascular research projects which are being conducted in state medical facilities. Due to Federal cutbacks and the economy, the Affiliate anticipates a critical research funding gap of over \$125,000 for 1992-93.

The American Heart Association, Arkansas Affiliate, Inc. is the only health agency whose sole mission is the reduction of disability and death from cardiovascular disease and stroke.

## Medicaid Develops Provider Denial Rate Report

The Arkansas Medicaid Program may be contacting your office in the near future if you make the "Top 25." A new report has been developed and is produced every two weeks for the Medicaid provider representatives that indicates the 25 providers that are experiencing the highest denial rates. This report also indicates the kind of denials by code to allow the

Medicaid Provider Representative to be able to research the provider's problem and call with the solution prior to a contact by the provider's office. For your interest a list of the five most frequent reasons for denial shown on the latest report is indicated:

- Primary diagnosis code errors
- Detail diagnosis code errors
- Late billing (over 6 months past service date)
- Medicare denied (cross over claims)
- Recipient not on file as eligible

Dr. Yamauchi, the director of the Department of Human Services, has followed the progress in the development of this report and feels that this tool will do much to assist providers in realizing fewer problems in filing Medicaid claims for services rendered Arkansas Medicaid recipients.

## AMA's Locum Tenens Service

Increasing numbers of physicians across the country are choosing to work as locum tenens because of the benefits offered through this style of practice - freedom with financial security, professional and personal challenge, adventure and travel.

Many physicians relish the freedom that locum tenens positions allow them. It is an ideal situation for those who enjoy travelling, continually meeting new people, and encountering challenges. They are relieved from the burden of practice management and the responsibilities of owning their own practices. Locum tenens have more time to concentrate on matters of personal interest.

The AMA offers a service for physicians looking for short-term positions and for practices recruiting temporary replacements. AMA's Locum Tenens Service provides recruiters and physicians with the widest possible exposure through listing locum tenens positions in AMA's *Opportunity Placement Register* and through presenting abbreviated curricula vitae of physicians in AMA's *Physician Placement Register*. Complete physician curricula vitae can be ordered through the Service by practices seeking locum tenens physicians. Physicians can also request profiles of practices offering locum tenens positions.

For more information about the AMA's Locum Tenens Service, please call the AMA's Physicians Career Resource, 1-800-955-3565.



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REFERRING PHYSICIAN SECONDARY  
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PLACE OF SERVICE CODE  
HICFA  
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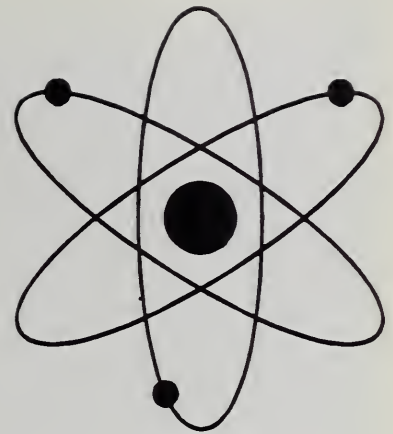
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# Radiological Case of the Month

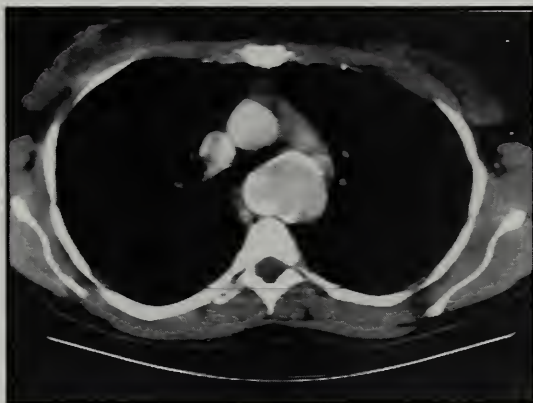
James L. Bulteman, M.D.  
Donald L. Patrick, M.D.  
Lane Wilson, M.D.  
Steven R. Nokes, M.D.  
David L. Harshfield, M.D.



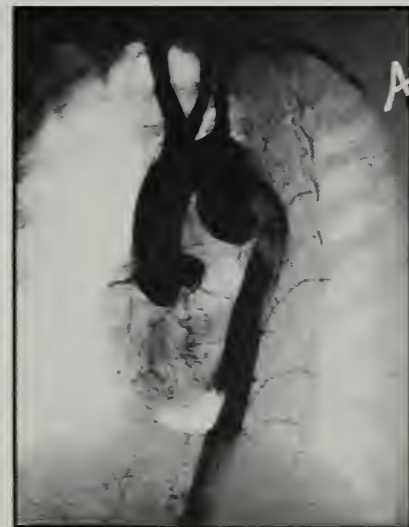
*Figure 1. PA and lateral chest film demonstrating a calcified mass in the upper middle mediastinum.*



*Figure 2. PA and lateral chest film demonstrating a calcified mass in the upper middle mediastinum.*



*Figure 3. Contrast enhanced CT showing the focal dilatation of the proximal descending aorta.*



*Figure 4. Aortogram showing the aneurysmal sacculum just distal to the origin of the left subclavian artery.*

## History:

This 35-year-old woman presented to the emergency room with chest pain. Surgical history was significant for trauma sustained in a severe motor vehicle accident seven years earlier, ultimately requiring right nephrectomy. Thoracic injuries included bilateral pulmonary contusions and right pneumothorax, complicated by adult respiratory distress syndrome.



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# Post-traumatic Pseudoaneurysm of the Thoracic Aorta

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## Radiographic Findings:

PA and lateral chest films show a calcified mass in the upper middle mediastinum displacing the left main bronchus. Contrast-enhanced CT shows focal dilation of the proximal descending aorta with dense calcification in the wall of the lesion. The large rounded aneurysmal sacculation just distal to the left subclavian artery confirms the diagnosis on the aortogram - this is the classic location for traumatic rupture of the thoracic aorta.

## Discussion:

Most patients with traumatic rupture of the thoracic aorta die instantly. Of the remaining 10-20% who survive, 50% will die within the first 24 hours and 90% within four months without surgical repair. Only 2% live long enough to develop a chronic pseudoaneurysm. With early diagnosis and repair, however, survival is excellent.

This injury most often occurs as a result of blunt deceleration trauma, such as a motor vehicle accident. In 80% the aorta is lacerated at the isthmus, just distal to the left subclavian artery. The proximal ascending aorta is the second most frequent site, but these are almost always fatal. Other areas include the descending aorta at the diaphragmatic hiatus and the transverse aortic arch.

In surviving patients the hemorrhage is initially contained by the aortic adventitia and mediastinal pleura. The danger of the catastrophic rupture into the left hemithorax remains present for the first few months. Beyond this, fibrosis occurs and a chronic pseudoaneurysm develops, enlarging at a very slow rate. These are recognized as late as 10 to 20 years after the initial injury. Symptoms result from compression of the left main bronchus. Many asymptomatic lesions are detected when a chest x-ray made for other reasons discloses a calcified mediastinal mass.

This patient did well following repair of the pseudoaneurysm with a 25mm straight tube graft. In this case, the diagnosis was suspected from the appearance on the lateral chest x-ray, emphasizing the importance of both frontal and lateral views in the detection of thoracic disease.

## References

1. Mirvis SE, et al. Value of chest radiography in excluding traumatic aortic rupture. *Radiology*, 1987; 163:487-93.
2. Kadir S. *Diagnostic Angiography*. Philadelphia, Penn. W.B. Saunders Co. 1986:149-54.
3. Rich MR Spencer FC. *Vascular Trauma*, Philadelphia, Tenn. W.B. Saunders Co. 1978:435-40.

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*Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and head of radiology at Riverside Radiologist Group in North Little Rock.*

*Editor: Steven R. Nokes, M.D., is director of CT/MRI for Radiology Consultants in Little Rock.*

*Contributor: James L. Builteman, M.D., is affiliated with Radiologists, P.A., in Fort Smith.*

*Contributor: Donald L. Patrick, M.D., is affiliated with the Holt-Krock Clinic in Fort Smith.*

*Contributor: Lane Wilson, M.D., is affiliated with the Cooper Clinic in Ozark.*



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# Resolution

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## Thomas Fletcher Dilday, Jr., M.D.

Whereas, the members of the Pulaski County Medical Society note with sincere sorrow the recent death of their esteemed colleague, Thomas Fletcher Dilday Jr., M.D.; and

Whereas, he was a faithful member of this organization for over 30 years, freely donating his time and energy towards its progress; and

Whereas, Dr. Dilday was highly respected by his colleagues in medicine and by the community at large; be it therefore

*RESOLVED*, that this resolution be adopted and made a part of the permanent archives of this Society; and

*RESOLVED*, that a copy of this resolution be sent to Dr. Dilday's family as a token of our heart-felt sympathy; and

*RESOLVED*, that a copy be forwarded to *The Journal of the Arkansas Medical Society* for publication.

Adopted  
Executive Committee  
January 15, 1992

By Order of the Memorials Committee  
Bruce E. Schratz, M.D., Chairman  
Henry Hollenberg, M.D.  
Robert Watson, M.D.

## Robert L. Sherman, M.D.

Whereas, the members of the Sebastian County Medical Society notes with sincere sorrow the recent death of their esteemed colleague, Robert L. Sherman, M.D.; and

Whereas, Dr. Sherman was a highly respected member of this organization for 37 years and had given generously of his time and talent to positions of leadership in the medical community; and

Whereas, his devotion to his patients and his community service will be long remembered; be it therefore

*RESOLVED*, that this resolution be adopted and stored in the permanent records of the Society; and

*RESOLVED*, that a copy be sent to Dr. Sherman's family as an expression of our heart-felt sympathy; and

*RESOLVED*, that a copy be made available to *The Journal of the Arkansas Medical Society* for publication.

Adopted by Sebastian County Medical Society  
January 21, 1992

# In Memoriam

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## Harry J. "Hank" Jordan Jr., M.D.

Dr. Hank Jordan, a Jonesboro physician, died Saturday, January 11, 1992. He was 44.

Dr. Jordan was a member of the Arkansas Medical Society and the Craighead/Poinsett County Medical Society.

Survivors are his wife, Harriette Jordan; a son, Rush Jordan of Jonesboro; a daughter, Kim Jordan of Jonesboro; his parents, Jack and Jewell Jordan of Jonesboro; and a sister, Julia Ann McWilliams of White Hall.

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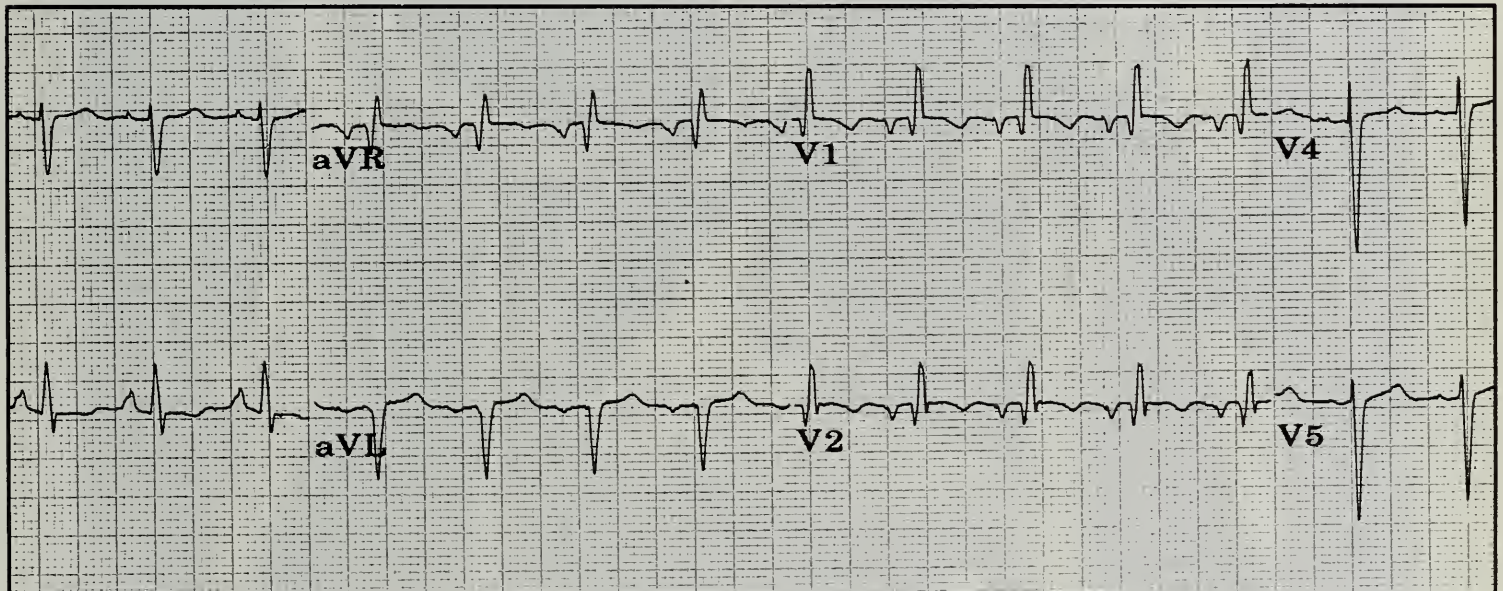


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## HISTORY:

This record was obtained from a 62-year-old woman who presented with a two week history of increasing lower extremity edema, orthopnea, and paroxysmal nocturnal dyspnea. Physical examination revealed a blood pressure of 140/90 and a respiratory rate of 20 breaths/min. Examination of the chest revealed rales in the lower half of the thorax while examination of the heart revealed an S4.



## DISCUSSION:

Sinus tachycardia is present with a rate of 105. Right axis deviation is present with a mean frontal plan axis of approximately 120. ST segment depression and T wave inversion are evident in the inferior leads. Leads V1 and V2 have pathologic Q waves and inverted T waves suggestive of an anteroseptal myocardial infarction of undetermined age. However, this record is diagnostic of right ventricular hypertrophy (RVH) and not myocardial infarction. Anterior myocardial infarction is generally associated with left axis deviation and not right axis deviation. The diagnosis of RVH is further supported by the presence of deep S waves in the lateral precordial leads (clockwise rotation) and a rightward axis of the P waves. Additionally, the right precordial leads demonstrate delayed intrinsicoid deflection with an interval of 0.06 seconds between the onset of the Q wave and the peak of the R wave in V1. The nonspecific ST and T wave abnormalities in the inferior leads are secondary to RVH. The diagnosis of RVH was confirmed by echocardiography which revealed a dilated and thickened right ventricle with normal left ventricle. The RV pressure was estimated to be greater than 60 mm Hg by Doppler.

RVH can mimic myocardial infarction in several ways. In this case, RVH mimicked an anteroseptal MI. Other patterns of RVH may mimic an anterolateral MI or true posterior MI by the presence of tall R waves in the right precordial leads and a progressive loss of R waves in the mid and left lateral precordial leads.



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**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix® may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0.4%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

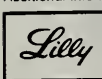
**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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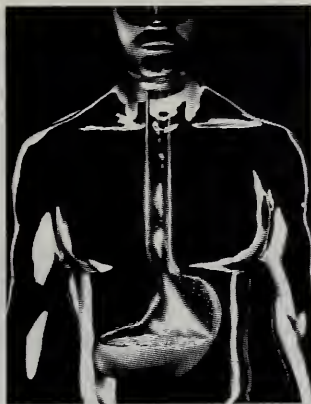
Additional information available to the profession on request.



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# Arkansas AIDS Report

## 1983-1992

Arkansas: June 1983 - January 31, 1991

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
S E X	Male	19	32	49	216	251	438	420	25	1,450	85.85
	Female	1	1	6	27	39	71	90	0	239	14.15
A G E	< 5	0	0	1	1	2	8	13	0	135	7.99
	5-12	0	0	0	1	1	5	1	0	8	0.47
	13-19	0	0	0	8	8	14	20	2	52	3.08
	20-29	8	10	15	109	124	192	151	13	622	36.83
	30-39	7	15	22	86	105	206	215	11	667	39.49
	40-49	4	7	11	24	35	61	72	1	215	12.73
	> 49	1	1	6	6	12	19	23	1	69	4.09
	Unknown	0	0	0	8	3	4	15	1	31	1.84
R A C E	White	16	24	47	171	177	353	309	18	1,115	66.02
	Black	4	9	8	70	107	152	195	11	556	32.92
	Other	0	0	0	2	6	4	6	0	18	1.07
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	29	1,689	100%

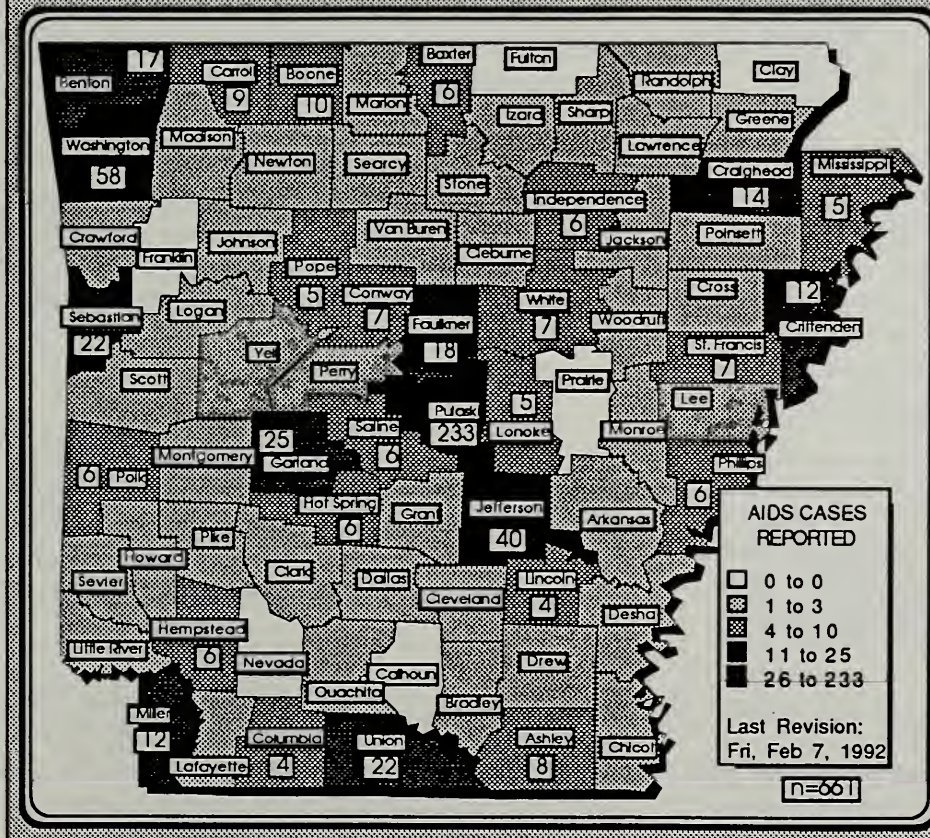
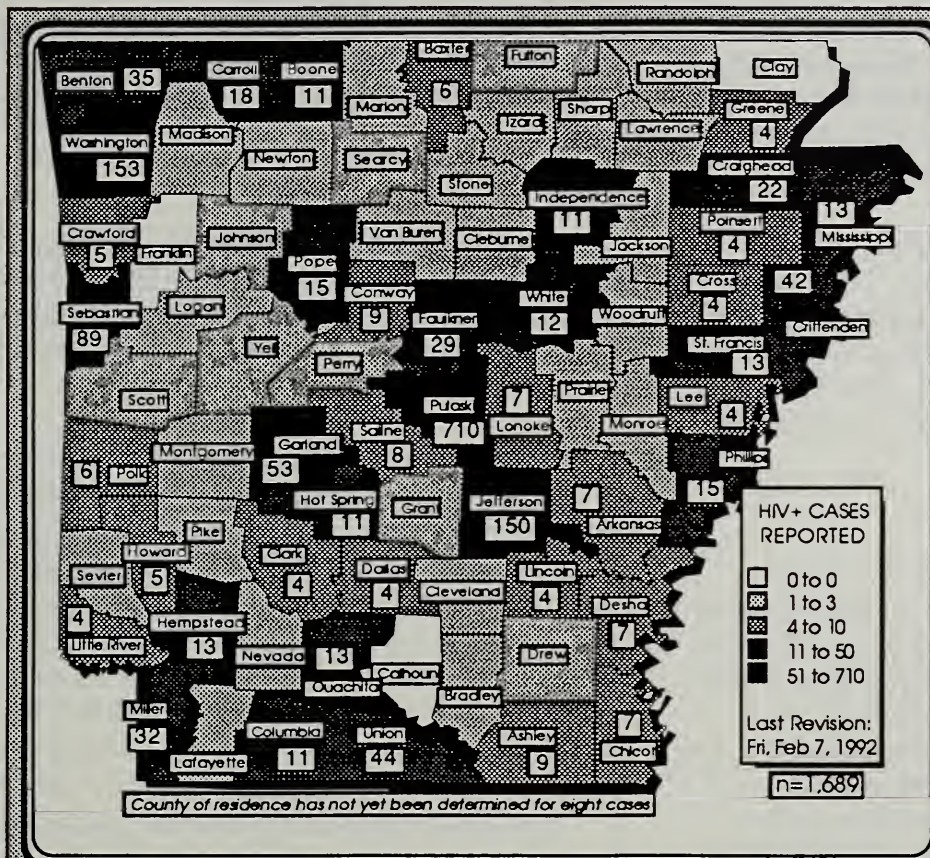
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
S E X	Male	11	28	46	77	70	170	176	16	594	89.86
	Female	1	0	4	6	10	20	25	1	67	10.14
A G E	< 5	0	0	0	1	1	6	6	0	14	2.12
	5-12	0	0	0	1	0	1	1	0	3	0.45
	13-19	0	0	0	0	0	4	3	0	7	1.06
	20-29	7	9	15	27	24	55	57	5	199	30.11
	30-39	3	13	23	36	41	78	80	8	282	42.66
	40-49	1	6	8	10	7	35	41	4	112	16.94
	> 49	1	0	4	8	7	11	13	0	44	6.66
R A C E	White	9	22	43	61	58	141	134	13	481	72.77
	Black	3	6	7	20	21	47	66	4	174	26.32
	Other	0	0	0	2	1	2	1	0	6	0.91
R I S K	Male/Male Sex	7	17	31	59	50	118	118	14	414	62.63
	Injection Drug User (IDU)	0	2	10	4	11	18	28	0	73	11.04
	Male/Male Sex & IDU	3	9	4	6	6	18	17	0	63	9.53
	Heterosexual	2	0	2	3	6	10	10	1	34	5.14
	Transfusion	0	0	2	7	3	7	11	0	30	4.54
	Perinatal	0	0	0	1	1	6	6	0	14	2.12
	Hemophiliac	0	0	0	1	1	5	5	0	12	1.82
	Undetermined	0	0	1	2	2	8	6	2	21	3.18
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	17	661	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas HIV/AIDS Report

## 1983-1992



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of:
  - Nursing Homes
  - Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# Things To Come

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## March 27-28

**Leukocyte Reduction and Blood Component Therapy.** Stouffer Concourse Hotel, Arlington, VA. Sponsored by the American Association of Blood Banks (AABB). Fees: \$200, members; \$250, non-members. For more information, contact Robin Grossfeld at (703) 528-8200.

## April 2-3

**19th Annual Obstetrics & Gynecology Symposium.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## April 22-26

**Symposium on Management of Common Infections in Practice; 12th Annual National Pediatric Infectious Disease Seminar; and Special Session on Risk Management in the Pediatric Office.** Grand Hyatt Hotel, Washington, D.C. Sponsored by the Department of Pediatrics, Southwestern Medical School, The University of Texas Southwestern Medical Center. Fees: \$350; \$250, residents, fellow, PA's and PNP's. AMA Category I, AAFP, and PREP credits available. For more information, contact Marian Troup at (214) 688-8845.

## April 22-26

**6th Annual Critical Care Update.** Hyatt Regency-Capitol Hill, Washington, D.C. Co-sponsored by the Society of Critical Care Medicine, Rush Presbyterian-St. Luke's Medical Center, in cooperation with the Critical Care Medicine Department of the Clinical Center of the National Institutes of Health. Category I credits available. For more information, contact Svetlana Lisanti at (201) 385-8080.

## April 24-25

**5th Hearing Aid Conference.** The Clarion Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## April 27- May 1

**25th National Conference on Breast Cancer.** The Westin Hotel, Copley Place, Boston, Massachusetts. Sponsored by the American College of Radiology.

## May 2-4

**18th Annual Meeting of the Federated Ambulatory Surgery Association.** The Boston Marriott, Copley Place. For more information, call (703) 836-8808.

## May 5

**Surgery in the Developing World.** The Royal Society of Medicine, London, England. For more information, contact Keith Newton at The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE.

## May 7-9

**2nd Annual Cardiovascular Disease Review & Update.** Hotel Inter-Continental, Chicago, IL. Sponsored by the Rush Heart Institute, Section of Cardiology, Department of Cardiovascular and Thoracic Surgery, Rush Presbyterian - St. Luke's Medical Center. Category I credits offered. For more information, contact Svetlana Lisanti at (201) 385-8080.

## May 15-16

**Advanced Laparoscopy for the General Surgeon.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## May 15-17

**Positron Emission Tomography.** Hilton, Walt Disney World Village, Lake Buena Vista, Florida. Sponsored by the American College of Radiology. For more information, contact Kathy Lawrence at 1-800-227-5463 ext. 4961.

## June 4-7

**Advances in Aesthetic & Reconstructive Breast Surgery.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## June 11-13

**Cornea & Contact Lens Conference.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.



### June 26-28

**Frontiers in Endourology.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

### June 29-July 3

**Origins of Coping with Stress.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 6-10

**Behavioral Medicine Applications.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 13-17

**Psychopharmacology Update.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 13-17

**Multiple Family Group Therapy for Abuse.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 20-24

**Personality and Political Behavior.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 27-31

**Learning Disorders in Childhood and Adolescence.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

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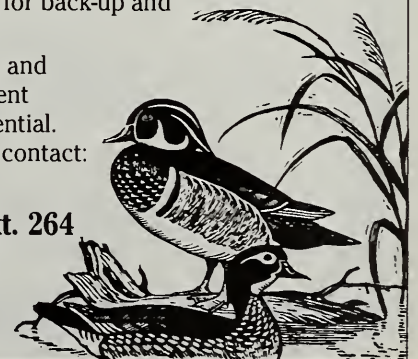
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# Keeping Up

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## **Symposium on Critical Care and Emergency Medicine**

March 26-28, 7:00 a.m., Arlington Hotel, Hot Springs. Sponsored by UAMS College of Medicine. Fees: \$200.00. CME Category I credits available.

## **Advanced Concepts in Electronic Fetal Monitoring**

April 3, 7:30 a.m., UAMS College of Medicine Education II room G-137. Sponsored by UAMS. Fees: \$20.00; \$10.00, students & employees. CME Category I credits available.

## **AMS 116th Annual Session**

April 9-11, Excelsior Hotel, Statehouse Convention Center, Little Rock. For registration information, see pages 476-485 of this issue of *The Journal*.

## **Ophthalmology Update**

April 10, J.A. Gilbreath Conference Center, Baptist Medical Center, Little Rock. For more information, call BMC Medical Affairs at (501) 227-2672.

## **9th Annual Arkansas Chest Symposium**

May 2-3, Inn of the Ozarks, Eureka Springs. Sponsored by the American Lung Association of Arkansas. For more information, call David Cook, American Lung Association, 1-800-880-5864, or Alicia Pierce, UAMS, (501) 686-5261.

## **Arkansas Hand Club Annual Meeting**

May 8-9, 1992, Gaston's White River Resort, Lakeview. For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

### **FAYETTEVILLE - VA MEDICAL CENTER**

Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Sleep Disorders Case Conference, every other Thursday, Sleep Disorders Center conference room. Lunch provided  
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served



### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1*

*GI Conference, 4th Friday, 12:00 noon, conference room 1*

*Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided*

*Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library*

*Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided.*

*Category 1 credits available.*

*Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided*

*Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided*

### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room*

*Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room*

*Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room*

*X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room*

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

### **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits*

*Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B*

*Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B*

*Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock*

*Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06*

*Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06*



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CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy  
 Cardiothoracic Surgery Conference, date, time, & location varies  
 Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
 Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D  
 Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room  
 CME Outreach Program, dates, times & locations vary  
 Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B  
 Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B  
 Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B  
 Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B  
 Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room  
 Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29  
 GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293  
 Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room  
 Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room  
 LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month  
 LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC  
 Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B  
 Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306  
 Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room  
 Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135  
 Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH  
 Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours  
 Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293  
 Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33  
 Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C  
 Neuurosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours  
 Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141  
 OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.



OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B  
 Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours  
 Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102  
 Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135  
 Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours  
 Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135  
 Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135  
 Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue  
 Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium  
 Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room  
 Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room  
 Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room  
 Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room  
 Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room  
 Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D  
 Urology Basic Sciences Conference, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
 Urology Clinical Didactic Conference, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
 Urology Formal Teaching (Grand) Rounds, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
 Urology Morbidity & Mortality Conference, once monthly, 5:00 p.m., VAMC-LR, 4D  
 Urology Pathology Conference, once monthly, 5:00 p.m., VAMC-LR, 4D  
 Urology Pediatric Conference, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
 Urology Teaching Conference, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
 Uro-radiology Conference (Urologic Imaging), 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
 VA Chest Conference (combined Surgical/Medical Chest Conference), Mondays, 12:15 p.m., VAMC-LR, room 2D109  
 VA Diagnostic Imaging Conference, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
 VA GRECC/Geriatric Research Conference, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
 VA Hematology/Oncology Conference, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
 VA Lung Cancer Conference, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
 VA Medical Service Teaching Conference, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
 VA Medicine-Pathology Conference, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
 VA Medicine Resident's Clinical Case Conference, Fridays, 12:00 noon, VAMC-LR, room 2D08  
 VA Physical Medicine & Rehab Grand Rounds, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
 VA Surgery Grand Rounds, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
 VA Topics in Rehabilitation Medicine Conference, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
 VA Weekly Cancer Conference, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
 White County Memorial Hospital Medical Staff Program, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## **EL DORADO - AHEC**

Behavioral Sciences Conference, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
 Chest Conference, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
 Gynecology-Pathology Conference, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
 Internal Medicine Conference, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
 Pathology Conference, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
 Pediatric Conference, last Monday, 12:30 p.m., AHEC - South Arkansas  
 Obstetrics-Gynecology Conference, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
 Surgical Conference, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
 Tumor Clinic, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

AHEC Teaching Conferences, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
 AHEC Teaching Conferences, Fridays, 12:00 noon, Fayetteville City Hospital  
 AHEC Teaching Conferences, Thursdays, 7:30 a.m., Washington Regional Medical Center

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 Chest Conference, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
 Citywide Cardiology Conference, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
 Clinical Faculty Conference, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided  
 Craighead/Poinsett Medical Society, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
 Eaker AFB CME Conference, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
 Independence County Medical Society, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
 Interesting Case Conference, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
 Jackson County Medical Society, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
 Kennett CME Conference, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
 Methodist Hospital of Jonesboro CME Conference, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
 Neuroradiology Conference, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
 Perinatal Conference, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
 Pocahontas CME Conference, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
 Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
 Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
 White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

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 Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
 Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
 Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
 Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
 Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
 Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
 Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
 Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
 Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
 Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
 Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

### **TEXARKANA-AHEC SOUTHWEST**

Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
 Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
 Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
 Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
 Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
 Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
 AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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Arkansas Blue Cross & Blue Shield .....	495
Arkansas Express Claims .....	529
Arkansas Medical Society Auxiliary .....	476
Calan - G.D. Searle & Company .....	inside back
<i>Bozell Healthcare, Inc.</i>	
Central Arkansas Rehabilitation Hospital .... back cover	
<i>Walker &amp; Associates</i>	
Cheraw Family Medicine .....	541
ClaimNet, Inc. ....	530
Collom & Carney Clinic Association .....	542
Eli Lilly & Company .....	536/537
<i>Garrison, Jasper, Rose &amp; Company</i>	
Tommy Farrell Associates .....	544/545
<i>Thomas J. Farrell Agency</i>	
IBM .....	537
<i>Thompson Recruitment Advertising</i>	
Medical Personnel Pool .....	513
Medical Protective Company .....	533
<i>Ferguson Advertising, Inc.</i>	
MEDX .....	542
Mississippi Methodist Rehab Center .....	506
<i>Maris, West &amp; Baker, Inc.</i>	
Orthopaedics .....	541
<i>Comp-Art of Louisville, Inc.</i>	
Palisades Pharmaceuticals .....	525
<i>Design and Advertising</i>	
Radiology Consultants .....	520
Rather, Beyer & Harper .....	527
Riverside Motors, Inc. ....	473
<i>Benson/Smith Advertising</i>	
Roche Laboratories .....	487/488
<i>Bryan, Brown &amp; Malinsky</i>	
State Volunteer Mutual Insurance Company .....	474
<i>The Maryland Group</i>	
Tanyard Springs .....	489
<i>A. Tim Irby Advertising, Inc.</i>	
U.S. Air Force .....	530
<i>Bozell, Inc.</i>	
U.S. Air Force Reserve .....	494
<i>Hameroff/Milenthal/Spence, Inc.</i>	

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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C./There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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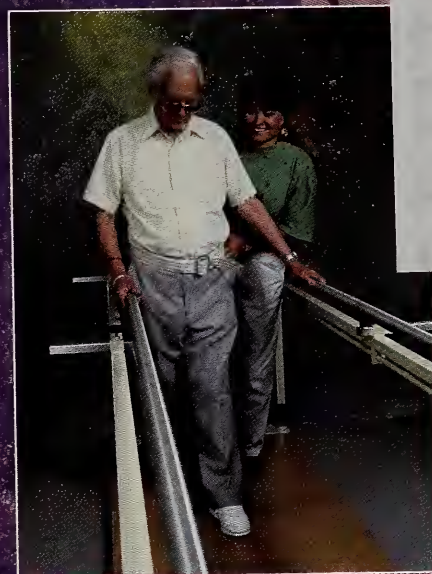
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Volume 88 Number 11

April 1992

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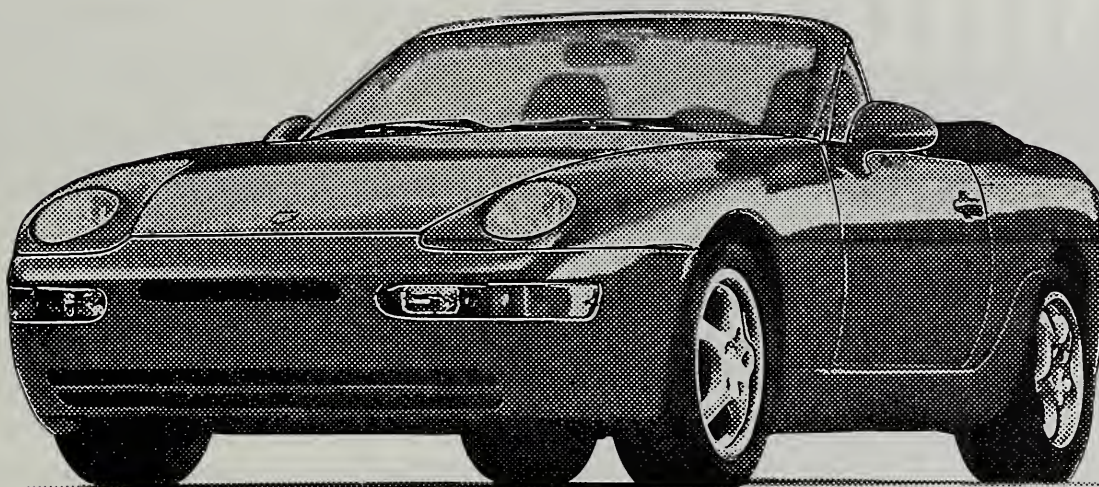
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# THE JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

Volume 88 Number 11

April 1992

## CONTENTS

### FEATURES

- |     |   |
|-----|---|
| 553 | <b>Pesticide Concentrations in Arkansas Breast Milk</b><br><i>Donald R. Mattison, M.D., et al</i>                           |
| 559 | <b>Long-Term Care Financing and Service Delivery: Meeting the Challenge in Arkansas</b><br><i>Krista L. May-Hughes, MAG</i> |
| 563 | <b>UAMS FATE Program Recognized by the AMA</b><br><i>Scott Stanley</i>  |
| 566 | <b>The A to B Approach to Investing</b><br><i>Graham Smith</i>  |
| 569 | <b>...To See Ourselves as Others See Us</b><br><i>Loss Prevention Case Study</i><br><i>Scott Berglund</i>                   |

### DEPARTMENTS

- |     |                                       |
|-----|---------------------------------------|
| 564 | <b>AIDS in Arkansas Statistics</b>    |
| 574 | <b>AMS Newsmakers</b>                 |
| 576 | <b>New Members</b>                    |
| 579 | <b>Radiological Case of the Month</b> |
| 583 | <b>Electrocardiogram of the Month</b> |
| 584 | <b>Medicine in the News</b>           |
| 586 | <b>Things to Come</b>                 |
| 588 | <b>Keeping Up</b>                     |

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# Pesticide Concentrations in Arkansas Breast Milk

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*During an episode of pesticide dairy product contamination in Arkansas in 1986, breast milk samples from 942 women were analyzed for concentrations of chlorinated pesticides. The pesticides found most frequently in quantifiable concentrations were p,p'-DDE (100%), oxychlordan (84%), trans-nonachlor (77%), heptachlor epoxide (74%) and beta-HCH, an isomer of lindane (27%). The pesticides present in highest mean concentrations of all samples analyzed (reported as ppm in milk fat) were p,p'-DDE (0.952 ppm), trans-nonachlor (0.062 ppm), oxychlordan (0.051 ppm), heptachlor epoxide (0.045 ppm), p,p'-DDT (0.039 ppm), and beta-HCH (0.032 ppm). These concentrations are lower than previous reports from similar regions of the US. However, continued persistence in human breast milk is of concern due to potential adverse health effects from these chemicals.*

**I**n January 1986, the U.S. Food and Drug Administration discovered that dairy products in Arkansas were contaminated with heptachlor epoxide, a metabolite of the chlorinated cyclodiene pesticide heptachlor. The contamination resulted from use of pesticide-treated fermented grains as feed for dairy cattle. Heptachlor is an insecticide, especially useful for control of termites by underground application. Other similar compounds include toxaphene, strobane, hexachlorobenzene, polychlorinated biphenyls,

DDT, chlordane and nonachlor. These compounds are heat-stable and persist in soil for long periods, though they are decomposed by sunlight.

Heptachlor is lipid-soluble, readily absorbed through skin, pulmonary and gastrointestinal epithelium. Once absorbed, heptachlor is metabolized to heptachlor epoxide by microsomal monooxygenases.<sup>1,4</sup> Heptachlor epoxide, the lypophylic metabolite, is stable and poorly metabolized. For these reasons it persists in human tissue for long periods. Breast milk is a major route of elimination.<sup>5-7</sup>

Concern for human exposure to compounds such as heptachlor is due to their biological persistence and from data demonstrating dose-dependent increases in rodent hepatocellular carcinomas following treatment with heptachlor, heptachlor epoxide or mixture.<sup>3,4</sup> Some of the other chlorinated pesticides have also been classified as suspected human carcinogens.<sup>3,4,8</sup> Use of these chemicals in animal feeds and human foods is prohibited.

The 1986 dairy product contamination caused concern among the population in general and considerable anxiety among pregnant women and nursing mothers. As a result of this concern Governor Clinton offered to provide, through the Arkansas Department of Health, analysis of breast milk for pesticide concentrations. This report summarizes the results of breast milk pesticide concentrations from 942 women who submitted breast milk samples for analysis.

## Materials and Methods

Standard procedures were carefully followed for the collection of breast milk. These included use of glass

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canning jars whose lids were lined with aluminum foil. The jars were rinsed with both water and organic solvent in the Department of Health laboratory before distribution to nursing mothers through county health clinics around the state. Mothers were instructed to express their milk manually and to avoid pumps for these specimens. At least 500 ml including both foremilk and hindmilk at several feeding episodes was requested. Specimens were frozen by the mothers when collected and kept frozen until preparation for analysis. This activity was carried out from April, through July, 1986. Mothers signed releases indicating their informed consent and permitting research uses of the specimens and related data.

*Laboratory Analysis of Breast Milk:* Five laboratories were used for breast milk pesticide analysis. Laboratories reported breast milk pesticide concentrations as parts per million (ppm) or a milk fat basis, uncorrected for internal standard (aldrin) recovery. In this report all values are reported as ppm in milk fat and are not corrected for aldrin recovery. Each laboratory followed its own variation of the GABICA method recommended by the EPA.<sup>9</sup> Fat concentrations were also reported. Laboratories generally reported pesticide concentrations below 0.05 ppm fat basis as "trace." These "trace" values were quantified by one of the authors (Brewster) from the original chromatograms as 3/4, 1/2 or 1/4 this limit of quantitation.

*Statistical Methods:* Pesticide concentration means, standard deviations and ranges were calculated separately for the total sample and for the subsample in which quantifiable levels of pesticides were present. Pesticide concentrations are reported as ppm milk fat and are not corrected for aldrin recovery.

## General Demographic Information

Approximately 1000 women participated in this voluntary breast milk survey. Participants ranged in age from 15 to 45 years with a mean ( $\pm$  SD) age of  $27.6 \pm 4.8$  years, approximately 3 years older than the mean of Arkansas women who delivered in 1986. The mean height was  $64.7 \pm 2.5$  inches and the mean weight at the time of collection of the breast milk sample was  $143.9 \pm 28.4$  lbs. The women participating in this study were predominantly white (95%) with a small number of black (3%), Hispanic, American Indian and Asian individuals. This contrasted with the racial characteristics of childbearing women in Arkansas during 1986, 76% of whom were white. Women participating in this study were considerably better educated than other women who delivered children in 1986. More than one-third were high school graduates, 20% had completed college and 7% had done graduate work. Only 10% of

the women who participated in this study had not finished high school. In contrast, less than half of the mothers who delivered in Arkansas in 1986 attained college degrees. In addition to being predominantly white and well educated, the women who participated in the study apparently had high incomes. One-third had annual incomes of \$25,000 or more and only 19% had incomes less than \$10,000. The distribution of income is not available for the state's mothers, but these figures exceeded Census Bureau estimates of household incomes.

Most of the women who participated in the study used municipal water (71%) while 24% consumed private well water. About half of the women had city sewage and the other half had septic systems. Most received prenatal care (99%), and most (94%) lived with the father of the child. Both of these proportions exceeded those of the state's mothers who delivered in 1986. As expected, about 2% of these mothers children had congenital malformations.<sup>10</sup> Approximately half of the women in the survey used breast pumps to collect breast milk while awaiting their breast milk test results.

On average this was the second or third pregnancy for the women. Before this pregnancy, their mean prepregnancy weight was  $135.8 \pm 27$  lbs. Average weight gain was  $31.4 \pm 12$  lbs. during the course of the pregnancy. The mean weight of the infants born to the women during this pregnancy was  $3530 \pm 524$  gms. The infants were  $19.4 \pm 17.8$  weeks old at the time the breast milk sample was collected for pesticide analysis. At the time of breast milk sampling many of the infants were also being supplemented with other foods including whole milk (9%), formula (49%), juice (48%), water (60%) and solids (51%). Among the women evaluated, 15% smoked and 25% consumed alcohol.

Because Arkansas is a south-central state, houses are frequently treated for termites. Previous studies have shown breast milk contamination with heptachlor and heptachlor epoxide following house treatment.<sup>11</sup> To explore the possibility that breast milk pesticides resulted from house treatment rather than from dairy product contamination we also requested information on the date of the last house treatment with pesticides prior to breast milk collection. The mean duration from the last house treatment to the time of breast milk collection was  $12.3 \pm 14.6$  months among the 605 women whose houses had been treated.

## Pesticide Concentrations in Breast Milk

*DDT and Metabolites:* The mean concentration of p,p'-DDT in all samples assayed in Arkansas was  $0.039 \pm 0.11$  ppm. Among those with quantifiable levels it was  $0.203 \pm 0.164$  ppm. Among all samples surveyed in Arkansas, the mean concentration of p,p'-DDE was  $0.952 \pm 1.65$  ppm and among those with quantifiable



concentrations the mean was  $0.954 \pm 1.647$  ppm. Previous surveys conducted in the US have found the mean concentration of p,p'-DDT to be between 0.2 and 4.3 ppm and p,p'-DDE to be between 1.2 and 14.7 ppm.<sup>6,7</sup>

**Dieldrin:** The mean concentration in the 2% of Arkansas samples with quantifiable levels was  $0.071 \pm 0.061$  ppm. The mean concentration among all samples was  $0.001 \pm 0.012$  ppm. The range of mean dieldrin concentrations reported in previous surveys of breast milk in the US was between 0.05 and 0.24 ppm in milk fat.<sup>6,7,13</sup>

**Lindane:** The beta-HCH isomer of lindane was found in 27% of the breast milk samples tested from Arkansas women. Among those with quantifiable levels the mean concentration was  $0.12 \pm 0.12$  ppm and among all samples the concentration was  $0.03 \pm 0.08$  ppm. Lindane and its isomers have been quantifiable in 4-68% of samples in previous studies. The range of mean concentrations reported was between 0.27 and 0.53 ppm.<sup>6,7,13</sup>

**Hexachlorobenzene:** Among the samples assayed in Arkansas, 6% had quantifiable levels with a mean concentration of  $0.03 \pm 0.02$  ppm in milk fat. Among all assayed samples the mean concentration was  $0.002 \pm 0.008$  ppm.

**Cyclodiene Pesticides:** Mean concentrations of heptachlor and heptachlor epoxide reported in previous studies of breast milk in the US were between 0.035 and 0.13 ppm.<sup>6,7,13</sup> Among samples assayed in Arkansas in which the pesticide was quantifiable, the mean concentration of heptachlor was  $0.03 \pm 0.02$  ppm and heptachlor epoxide was  $0.06 \pm 0.05$  ppm. The concentrations of oxychlordane and chlordane reported in prior surveys in the US were between 0.05 and 0.12 ppm.<sup>6,7,13</sup> The mean concentrations among quantifiable samples measured in Arkansas for trans-chlordane, cis-chlordane and oxychlordane were  $0.18 \pm 0.14$ ,  $0.15 \pm 0.11$  and  $0.06 \pm 0.04$  ppm in milk fat, respectively.

**Polychlorinated Biphenyls:** Among previous survey between 20-100% of breast milk samples assayed contained PCB's.<sup>6,7,13</sup> Only 0.6% of the samples surveyed in Arkansas contained quantifiable levels of PCB. However, some of the laboratories may have used sample preparation techniques which remove PCB's. The mean concentrations in the previous surveys ranged between 0.8 and 1.5 ppm. Among the quantifiable samples assayed from Arkansas the mean concentration was  $1.57 \pm 0.45$  ppm. Among all samples the mean concentration was  $0.01$  ppm  $\pm 0.13$  in milk fat.

## Discussion

This self-selected sample of nursing mothers was

older and better educated than other Arkansas mothers. Whether they also differed from other nursing mothers is not known. In the 1970's breastfeeding women in the US were better educated than those who bottle fed their infants. Such may have also been true of Arkansas mothers in 1986.

DDT is a highly effective pesticide which has little acute toxicity and a long history of application worldwide.<sup>1-4,8</sup> It has been credited with the virtually complete eradication of malaria in some areas. However, concern over its reproductive effects in birds, its possible health effects in humans and its long biological persistence led to the cessation of DDT use in the US approximately 20 years ago.<sup>1,2,8</sup> DDT was also one of the first pesticides detected in breast milk.<sup>12</sup> When it was used, DDT was generally composed of 70-90% p,p'-DDT and 10-20% o,p'-DDT. Metabolism and degradation are responsible for the formation of o,p'-DDE, p,p'-DDE, p,p'-DDD and o,p'-DDD.<sup>1,2,8</sup>

Surveys conducted prior to 1986<sup>6,7,13</sup> demonstrated that p,p'-DDT and/or its metabolite p,p'-DDE were found in quantifiable concentrations in essentially all breast milk samples assayed. Among breast milk samples surveyed in Arkansas in 1986 quantifiable concentrations of p,p'-DDT were found in 19% of the specimens, and its metabolite p,p'-DDE was found in all specimens. The range of means of p,p'-DDT and p,p'-DDE reported in breast milk surveys in the US prior to 1986 varied from 0.2-4.3 ppm and 1.2-14.7 ppm in milk fat respectively. The mean concentrations among quantifiable samples from the survey in Arkansas were at the low ends of these ranges. Among all samples the mean concentrations were considerably below those previously reported.

Dieldrin is an oxygenated metabolite of aldrin with a longer persistence in adipose tissue. Because of persistence and toxicity, aldrin, the parent compound, has generally been removed from use in developed countries.<sup>1,2,8</sup> Previous surveys conducted in the US have identified detectable levels in 0.04-100% of the human breast milk samples analyzed.<sup>6,7</sup> Only 2% of the samples analyzed in Arkansas had quantifiable levels of dieldrin.

Lindane is a mixture of various isomers of hexachlorocyclohexane (HCH). The composition of the commercial pesticide (Reuber 1980) is: alpha-HCH (53-70%), beta-HCH (3-14%), gamma-HCH (11-18%), delta-HCH (6-10%) and other isomers (3-10%). Lindane has been a substitute for DDT. Previous surveys in the US have found quantifiable concentrations of the HCH isomers in 4-68% of breast milk samples analyzed.<sup>6,7,13</sup> Alpha-HCH and gamma-HCH, because of more rapid clearance, are generally found in fewer samples and in lower concentrations. That was also seen among the samples analyzed in Arkansas. However, because of its persistence, beta-HCH is typically found in more samples at quantifiable levels and in higher concentrations. This



too was observed in 1986 Arkansas breast milk samples.

Hexachlorobenzene, a persistent pesticide which is also used in the synthesis of pentachlorophenol, can disrupt porphyrin metabolism.<sup>6,7</sup> Fatal cases of infant poisoning have been reported from ingestion of highly contaminated breast milk. Because of its persistence and fat-solubility, hexachlorobenzene has been detected in many surveys of adipose tissue and breast milk.<sup>6,7</sup> Despite the fact that hexachlorobenzene has been detected in human adipose tissues in the US, few studies have explored the presence of this chemical in breast milk. Among previous surveys conducted in the US the mean concentration was 0.04 ppm in milk fat (range 0.018-0.063). Among the 6% with quantifiable levels in Arkansas the mean was 0.03 ppm, and among all samples the mean concentration was 0.002 ppm; both are lower than prior reports.

Heptachlor and chlordane and their metabolites (heptachlor epoxide, oxychlordane, trans-nonachlor) are closely related cyclodiene pesticides.<sup>1,4,8</sup> Previous surveys have demonstrated that 25 to 100% of breast milk samples had quantifiable concentrations of heptachlor or heptachlor epoxide. A somewhat greater proportion of samples (46-100%) had quantifiable concentrations of chlordane and oxychlordane, perhaps reflecting frequent use as a termiticide for house treatment.<sup>1,4,8</sup> In Arkansas, 5% had quantifiable concentrations of heptachlor, and 74% had quantifiable concentrations of heptachlor epoxide, 2% had quantifiable concentrations of chlordane, and 77% and 84% had quantifiable concentrations of trans-nonachlor and oxychlordane, respectively.

In most studies heptachlor and/or heptachlor epoxide can be detected in human adipose tissue samples. Curley et al<sup>14</sup> measured the concentration of chlorinated insecticides in fat samples from 241 Japanese individuals and found heptachlor epoxide concentrations which ranged from <0.01 to 0.2 ppm with a mean of 0.02 ppm. A Finnish study<sup>15</sup> demonstrated mean human adipose tissue heptachlor epoxide concentrations of 2.7 ug/kg in males and 1.9 ug/kg in females. The difference in male and female mean concentrations may reflect different volumes of adipose tissue or elimination via breast feeding.

A national representative or probability sample conducted by Savage<sup>16</sup> explored regional differences in breast milk pesticide content. In the Southeast region of the US, which includes Arkansas, 76% of breast milk samples had detectable levels of heptachlor epoxide. The average heptachlor epoxide concentrations was also higher in the Southeast region than in the US. Half of the samples (52%) had concentrations of heptachlor epoxide between 0.001 and 0.1 ppm with the remainder (approximately 25%) having concentrations above 0.1 ppm. This was the highest of all regions in the US. The mean concentration of heptachlor epoxide in these

samples with detectable levels was  $0.128 \pm 0.209$  ppm, also the highest mean level in the regions surveyed throughout the US.

Similar breast milk studies in Pennsylvania<sup>17</sup> and Missouri<sup>18</sup> have demonstrated mean heptachlor epoxide concentrations of 0.16 ppm and 0.0027 ppm respectively. Studies in Hawaii,<sup>19,20</sup> a state in which citizens have also been exposed to heptachlor and heptachlor epoxide in dairy products, have demonstrated levels ranging between 0.001 and 0.0067 ppm with a mean concentration of 0.036 ppm among women on Oahu, where exposure occurred, and 0.015-0.052 ppm with a mean concentration of 0.031 ppm for women on neighboring islands.

Chlorinated organic pesticides are found in most US residents, and tissue concentrations are highest among those living in regions where the use of these pesticides is most common. Many of these lipid-soluble compounds are not cleared from organisms rapidly. Breast milk is one route of elimination, but unfortunately that route increases infant exposure.<sup>6,7,13</sup> Quantitative risk-benefit ratios for breast feeding may be the best available criteria to determine advisability and duration of breast feeding. Quantitative risk assessments for consumption of contaminated breast milk have been attempted.<sup>13,21-25</sup> However, more studies are needed in animals and humans to characterize the putative adverse health effects.

This exposure episode concerned a product that was a mixture of heptachlor and chlordane. Both were found in low concentrations in the majority of breast milk samples tested, in agreement with the surveys described. In contrast to DDE, there was no relationship of these two pesticides and their metabolites to maternal age, suggesting that their presence may not necessarily be ascribed to ubiquitous exposures of life.<sup>26</sup> In 1986 this situation left physicians, their patients and health officials without a sound basis for advice about starting or continuing breastfeeding. At the outset of the emergency it was not certain whether breast, bovine or formula milk had least heptachlor or heptachlor epoxide. Once contaminated cows milk was removed from markets, the debate turned to balancing the widely accepted benefits of nursing to potential hazards of several compounds present in unknown concentrations. The expense and complexity of testing a thousand breast milk specimens delayed information about concentrations from one to four months, enough to render it of dubious value in any decision to nurse. However, the combined results of these 942 determinations allowed us to conclude that these Arkansas mothers were carrying no more halogenated pesticides in their breast milk than others in the US. Whether the ingestion of these compounds at the concentrations measured during breastfeeding contributes to any adverse health effects over the life of these infants remains to be



defined. The database developed in the course of this study will serve as a useful tool for future analysis of these women and their children.

## Acknowledgements

The authors would like to acknowledge the participation of the women of Arkansas in this study, without whose cooperation this advance in our understanding of pesticides in breast milk would not have occurred. Additional thanks are due to the many employees of the Arkansas Department of Health who participated in many phases of this research. Creation of the database and this analysis was supported in part by cooperative agreement CR-813742-01-0 with the USEPA. The views expressed in this paper are those of the authors and do not necessarily reflect the views or policies of the US Environmental Protection Agency.

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

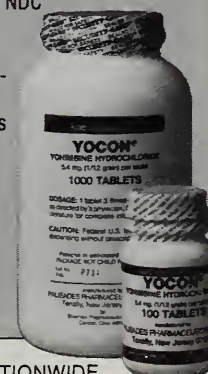
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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# Long-Term Care Financing and Service Delivery: Meeting the Challenge in Arkansas

Krista L. May-Hughes, MAG\*

**T**his country is experiencing unprecedented demographic changes, especially in the areas of life expectancy, proportion of elderly in the population, health status, and needs for health and long-term care. As more Americans reach old age, our nation must make critical decisions regarding the care to those who are frail and disabled.

As individuals age, acute conditions become less frequent and chronic, long-term conditions become more prevalent. Long-term care (LTC) is a combination of health, social, and other services delivered over a sustained period of time to persons with chronic care needs. It is estimated that over 24 million people need long-term care.

As in the rest of the country, Arkansas' elderly are growing in number. Meeting the LTC needs of our aging population is one of the most formidable challenges facing our state. Success in meeting this challenge will require involvement of policy makers as well as health and human service professionals. Physicians and other primary health care professionals play a crucial role in assisting patients obtain needed care. For many frail and impaired older people, their physician serves as the primary link between them and the community. Data suggests that physicians influence possibly as much as 70% of the decisions regarding the use of health care resources. Knowledge of existing and new service programs can enable physicians to better serve their patients. Involvement from physicians can help

shape or modify the current system of care into one more responsive to its needs, thereby enhancing the quality of life for thousands of Arkansans.

The escalating costs of LTC can be devastating, with most older people having little protection. The financing of LTC comes primarily from two sources: private out-of-pocket payments by individuals and public payments by Medicaid. Almost half of the cost of LTC (48.4%) is paid directly out-of-pocket by individuals and their families. Medicare and private insurance cover less than 3% and Medicaid accounts for 44.4%. Medicaid requires many to "spend down" their life savings to become eligible. And while the preferred setting for LTC is in the home, Medicaid is structured to deliver care in the most restrictive environment, in institutions, regardless of the necessity. These institutions, nursing homes, provide a range of services that cover most of a client's needs, including shelter, house-keeping, meals, medication, and nursing. However, where a choice exists, most people will choose to be cared for at home.

Arkansas has begun efforts to create and expand the home and community based LTC service system. Limited state resources have been made available to introduce Personal Care and other home and community based LTC services. The effectiveness of these services provided the impetus to develop additional financing strategies to enable the state to serve more elderly Arkansans.

One strategy is a newly implemented program called ElderChoices. This is a Medicaid home and community based "waiver" program authorized by the Health Care Finance Administration (HCFA). The legislation authorizing this program waives existing regu-

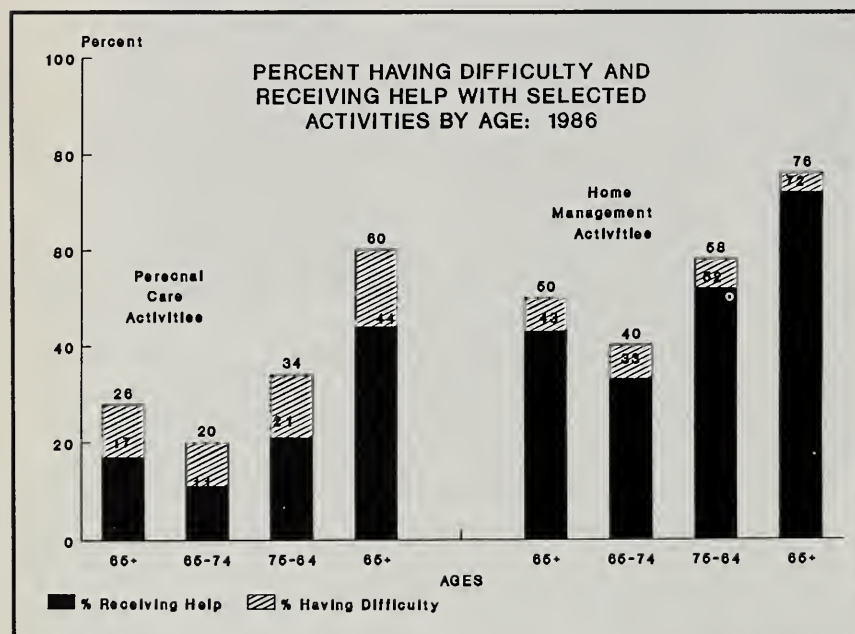
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\* Krista May-Hughes is the assistant director of the Division of Aging and Adult Services of the Arkansas Department of Human Services.



lations and permits states to finance non-institutional LTC services through Medicaid. This legislation responds to a national dilemma, the institutionalization of the elderly, disabled and chronically ill because of the absence of financing for home and community based alternative services. ElderChoices, in essence, redirects the Medicaid LTC dollar.

In order to maintain some element of fiscal control over such programs, HCFA places certain restrictions on the states. One restriction is the requirement to serve only those clients for whom there is a medical need equal to that required for nursing home placement. This restriction requires each applicant for ElderChoices to be assessed through a process identical to that used for nursing home admission. This restriction has promoted confusion and frustration similar to other Medicaid driven programs.



In addition to the medical necessity restriction, HCFA mandates that the program serve only those persons that the State has capacity to serve otherwise through vacant existing and projected nursing home beds. This limits the number of persons served under ElderChoices to approximately 3000.

Although these and other restrictions make the program difficult to administer, the personal benefits derived by our state's elderly justify the involvement and commitment of all medical, health and human services professionals dedicated to making this program a success.

ElderChoices delivers an array of services, focusing on Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) as critical indicators of quality of life and need for LTC in the elderly. A 1986 survey found that 28.3% of older Arkan-

sans living in the community had health related difficulties with one or more personal care activities (ADLs), and 49.5% had difficulty with one or more home management activities (IADLs).

This survey found that 17.4% of older non-institutionalized Arkansans received help with personal care activities. Of these, 12.9% received assistance from informal caregivers (i.e., family and friends), 3.8% from formal service providers, 0.7% from a combination of informal and formal services and 10.9% reported having these difficulties and receiving no services. The percentages needing and receiving help increased sharply with age.

The same survey found that 43% of older Arkansans received help with home management activities. Of these, informal caregivers provided services to 21.5%, formal caregivers served 13.8%, and 7.8% received a combination of formal and informal services. Another 6.4% reported having these difficulties and receiving no services.

The ElderChoices services, which are otherwise not available through Medicaid, are specifically designed to meet the needs identified in the survey. The services are:

**Adult Day Care:** A group program which offers minimal personal care, socialization and supervision to frail older adults.

**Adult Day Health Care:** A group program providing rehabilitative, therapeutic and supportive health services and social activities to frail persons.

**Personal Emergency Response System:** An in-home, 24 hour electronic system that enables a frail or homebound person to obtain immediate help in the event of an emergency by pressing a portable "help" button.

**Homemaker/Chore:** Basic upkeep and management of a person's home as well as assistance with laundry, essential shopping, errands, and meal preparation.

**Home Delivered Meals:** One meal per day delivered to persons who are homebound and unable to prepare meals.

**Adult Foster Care:** An alternative living situation in which one or two persons reside with and are cared for by an unrelated caregiver.

**Respite Care:** Temporary relief for those providing long term care at home. This care can be provided by a trained worker in the client's home or in a licensed facility.



One important benefit of ElderChoices is that it makes needed non-medical services available to many Arkansans who were previously unable to secure such services. This is in part because thousands of elderly Arkansans have incomes too low to purchase services and too high for Medicaid eligibility.

As a rule, Medicaid requires a person who receives services in the community to be more impoverished than a person receiving comparable services in a nursing home. In other words, an elderly person may have a maximum monthly income of \$422 to qualify for Medicaid assistance in the community. This is equal to the Supplemental Security Income (SSI) level. However, a nursing home resident is allowed to have a monthly income up to 300% of the SSI level, or \$1266. ElderChoices, allowing the maximum income level to be \$1266, provides an exception to the traditional rule and equalizes the income requirement for home and community services with that of nursing home care.

Perhaps the most powerful feature of ElderChoices is that it affords access to other needed services, such as physician's visits, prescription drugs, skilled home health and personal care, covered under Medicaid.

Governor Clinton has referred to ElderChoices as a "civil rights opportunity for the older people of this state." It enables a vulnerable portion of our population to exercise the same rights and liberties enjoyed by other Americans.

The LTC system of tomorrow is being shaped today through federal and state legislation and financing strategies. ElderChoices is among the first efforts to break the institutional bias of Medicaid and to redirect those resources into the preferred home and community settings. It is hoped that ElderChoices will increase the quality of life for thousands of elderly Arkansans and help shape a brighter tomorrow for thousands more to come.

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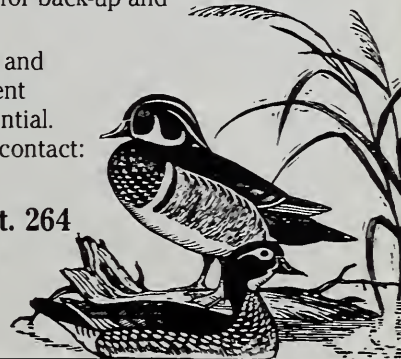
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## UAMS FATE Program Recognized by the AMA

**I**n March, 1988, the American Medical Association - Medical Student Section (AMA-MSS) initiated a national service project entitled "AIDS Education: Medical Students Respond." Over 100 medical schools responded by sending representatives to the AMA-MSS national training conference. University of Arkansas representatives returned from this conference and organized a sophomore class project called FATE (Fighting AIDS Through Education). With financial support from the Arkansas Medical Society, FATE developed a program to teach high school students about HIV infection.

Since 1988, the AMA-MSS has documented more than 70,000 student contacts from programs across the country, and Arkansas' FATE program logged more than 20,000 of those contacts. In January, 1991, the AMA-MSS recognized FATE, under the director of then-coordinator Rob Emery, as the leading program in the country. Last year FATE documented 6,500 contacts in high schools across Arkansas.

FATE has continued its unprecedented growth this year. FATE coordinator Scott Stanley, and co-coordinators Beth Berry, Karen Cormier, Kim Garner and John Honeycutt each lead FATE teams of about a dozen sophomore students. The teams visit Arkansas high schools and present a program modeled from the curriculum developed in the 1988 conference. Each sophomore student volunteers his/her time to participate in training and to serve at several speaking engagements. This year more than half of the sophomore class is involved in the service project.

During the first term of the 1991-1992 school year, FATE visited 11 high schools and made over 5,000 contacts. FATE has agreed to present to 10 more schools in the Spring term, and they expect the program to have reached between 10,000 and 12,000 high school students by year's end.

FATE has flourished, in no small part, because of support from UAMS and the community itself. UAMS medical school administrators are in constant contact with the FATE program, assisting in innumerable ways. The faculty have responded by excusing class absences and allowing make-ups for pop quizzes. Faye Bard, AHEC Education Coordinator oversees AHEC's support for FATE involving everything from clerical support to transportation. The program receives dozens of requests for presentations each year. While some school districts are hesitant to allow outside speakers to discuss controversial topics in their schools, administrators welcome the medical students because of their professionalism, their ability to relate to high school age students, and their unique academic and medical perspective on the AIDS epidemic. Many schools plan preparatory lectures and follow-up classes around the FATE presentation to maximize the educational experience. Students are generally mature, well behaved and often ask intelligent and thoughtful questions.

In the near future FATE plans to revise its training manual, and develop a Teacher's Guide to assist in each school's preparation for the FATE visit. Summer programs have now requested educational assistance from FATE and speaking engagements are being planned for this June.

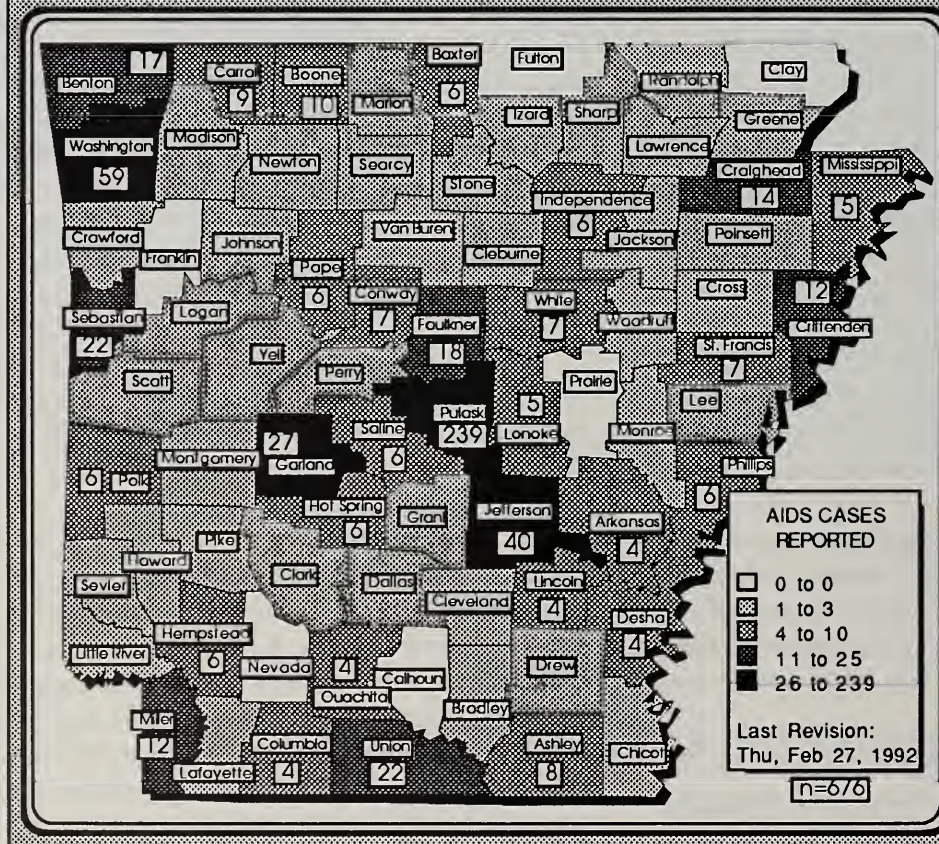
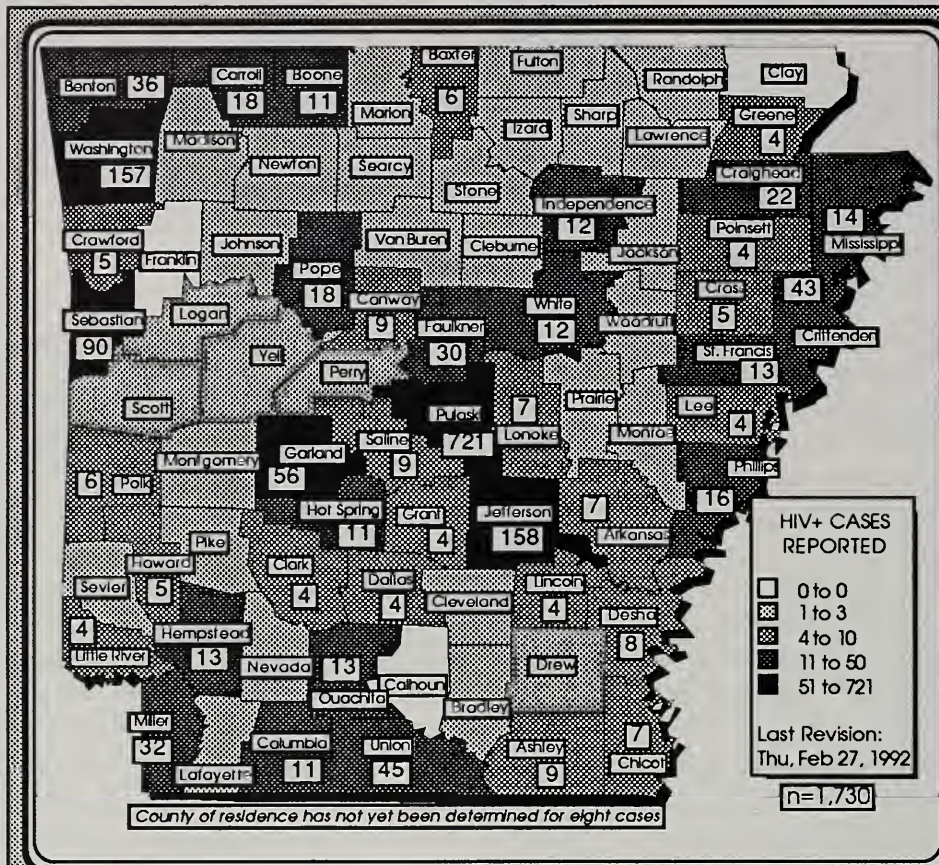
Over the last four years, FATE has grown to fill an existing void. Some school's requests cannot be honored because the medical student's time is so limited. One school even requested that the medical students develop a curriculum for pre-school and kindergarten students; such requests are far beyond FATE stated aims. Clearly, if FATE's scope were any larger, it would be undue demands on the medical students' primary educational objectives. But what is noteworthy is the lay public's perceived need for AIDS information from qualified health care professionals, and in this case, from medical students. The FATE experience is teaching medical students that the physician's role in the community is an expanded one, and it is resurrecting the archaic meaning of Doctor: TEACHER.

\* Mr. Stanley is a medical student at the University of Arkansas for Medical Sciences. He is the coordinator for the FATE program for the 1991-92 school year. He is also a member of the AMS AIDS Committee.



# Arkansas HIV/AIDS Report

## 1983-1992



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of: Nursing Homes, Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.



# The ACCUPRIL Single-Agent Commitment<sup>TM</sup>

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ONCE-A-DAY ‡  
**ACCUPRIL<sup>®</sup>** <sup>TM</sup>  
quinapril HCl tablets 10, 20, 40 mg

\* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.



## Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

### INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

### CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

### WARNINGS

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

**Hypotension:** Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

**Fetal/Neonatal morbidity and mortality:** ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at  $\geq 25$  mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

### PRECAUTIONS

#### General

**Impaired renal function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

**Evaluation of hypertensive patients should always include assessment of renal function** (see DOSAGE AND ADMINISTRATION).

**Hyperkalemia and potassium-sparing diuretics:** In clinical trials, hyperkalemia (serum potassium  $\geq 5.8$  mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

**Surgery/anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients

**Angioedema:** Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

**Symptomatic hypotension:** Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

**Hyperkalemia:** Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

## Accupril® (Quinapril Hydrochloride Tablets)

**Neutropenia:** Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

### Drug Interactions

**Concomitant diuretic therapy:** As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

**Agents increasing serum potassium:** Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

**Tetracycline and other drugs that interact with magnesium:** Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

**Lithium:** Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

**Other agents:** Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

### Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m<sup>2</sup> basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively).

#### Pregnancy

**Pregnancy Category D:** see WARNINGS, Fetal/Neonatal morbidity and mortality.

#### Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

#### Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

#### Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

### ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

**General:** back pain, malaise

**Cardiovascular:** palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

**Gastrointestinal:** dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

**Nervous/Psychiatric:** somnolence, vertigo, syncope, nervousness, depression

**Integumentary:** increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

**Urogenital:** acute renal failure

**Other:** amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

**Angioedema:** angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

**Clinical Laboratory Test Findings**

**Hematology:** (See WARNINGS)

**Hyperkalemia:** (See PRECAUTIONS)

**Creatinine and blood urea nitrogen:** Increases ( $>1.25$  times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

\* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



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# Arkansas AIDS Report

## 1983-1992

Arkansas: June 1983 through February 1992

HIV		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
S E X	Male	19	32	49	216	251	438	420	60	1,485	85.84
	Female	1	1	6	27	39	71	90	10	245	14.16
A G E	< 5	0	0	1	1	2	9	13	0	26	1.50
	5-12	0	0	0	1	1	5	2	0	9	0.52
	13-19	0	0	0	8	8	14	20	3	53	3.06
	20-29	8	10	15	109	124	192	151	36	645	37.28
	30-39	7	15	22	86	105	206	216	24	681	39.36
	40-49	4	7	11	24	35	61	72	5	219	12.66
	> 49	1	1	6	6	12	19	23	1	69	3.99
	Unknown	0	0	0	8	3	3	13	1	28	1.62
R A C E	White	16	24	47	171	177	353	309	39	1,136	65.66
	Black	4	9	8	70	107	152	195	29	574	33.18
	Other	0	0	0	2	6	4	6	2	20	1.16
TOTAL HIV+ CASES BY YEAR		20	33	55	243	290	509	510	70	1,730	100%

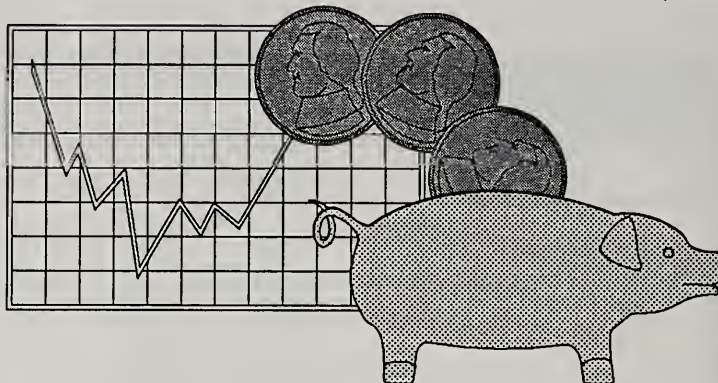
AIDS		1983-5	1986	1987	1988	1989	1990	1991	1992	Total	%
S E X	Male	11	28	46	77	70	170	176	31	609	90.09
	Female	1	0	4	6	10	20	25	1	67	9.91
A G E	< 5	0	0	0	1	1	6	6	0	14	2.07
	5-12	0	0	0	1	0	1	1	0	3	0.44
	13-19	0	0	0	0	0	4	3	0	7	1.04
	20-29	7	9	15	27	24	55	57	9	203	30.03
	30-39	3	13	23	36	41	78	80	15	289	42.75
	40-49	1	6	8	10	7	35	41	7	115	17.01
	> 49	1	0	4	8	7	11	13	1	45	6.66
R A C E	White	9	22	43	61	58	141	134	22	490	72.49
	Black	3	6	7	20	21	47	66	9	179	26.48
	Other	0	0	0	2	1	2	1	1	7	1.04
R I S K	Male/Male Sex	7	17	31	59	50	118	118	24	424	62.72
	Injection Drug User (IDU)	0	2	10	4	11	18	28	3	76	11.24
	Male/Male Sex & IDU	3	9	4	6	6	18	17	0	63	9.32
	Heterosexual	2	0	2	3	6	10	10	2	35	5.18
	Transfusion	0	0	2	7	3	7	11	0	30	4.44
	Perinatal	0	0	0	1	1	6	6	0	14	2.07
	Hemophilic	0	0	0	1	1	5	5	0	12	1.78
	Undetermined	0	0	1	2	2	8	6	3	22	3.25
TOTAL AIDS CASES BY YEAR		12	28	50	83	80	190	201	32	676	100%

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# The A to B Approach to Investing

Graham Smith\*



Over the past 12 months, our economy has changed in major ways. The stock market has entered uncharted waters and interest rates are the lowest that we have seen in over a decade. These events, plus others, have left many investors puzzled upon the best alternatives that exist for their financial well-being.

One thing that is important to remember is that our economy has been in similar situations before. History has shown that we live in a cyclical environment and that the one thing that you can count on is "change." Therefore, it is important that you not only look at where we are now, but what lies ahead.

The investment products that exist today allow investors the opportunity to be as active or inactive as the investor wishes. This is a tremendous advantage that we have, but can also be a detriment when trying to decide what is best for us individually. If you will approach investing with the right strategy, it can make the decision process a lot easier.

It is important to remember that what the investor is trying to accomplish is what is really important. Lou Holtz once said, "Not knowing where you want to go is as difficult as coming back from a place you have never been before." This also holds true for investing. Once you have identified what you are trying to accomplish, you should then choose the investment vehicle that will help you reach your destination.

## The Approach

The A to B Approach is one used by both professional financial advisors as well as individuals. The

process is simple in theory and should remain so in practice.

The A to B Approach lets us examine our finances as we would a road map before taking a trip. We are currently at point A and where we want to be in the future is point B. Common sense will tell us that the shortest and safest path should be the one most desired. By identifying where we want to go, you can have more assurance of reaching your destination. Your financial savings can be viewed in the same manner. By identifying where you are now and where you want to be in the future, you can have more assurance in reaching your desired goals.

## Point A

Point A is the identification of where you are now. This can be determined by examining the money you currently have invested. Included in this would be all cash accounts, IRAs, term and cash-value insurance, annuities and any other investments you have currently made. You also need to examine what provisions you have made for estate planning in the event of a catastrophic illness.

## Point B

After you have gathered all of your financial information, you must examine what major financial hurdles you have to face in the future. Some of the more obvious hurdles would be college educations, retirement and making your investments last throughout your retirement years. Individuals with estates valued at more than \$600,000 may also need to take a look at how their assets will be affected by estate taxes.

This gives you an idea what lies in front of you. Assigning arbitrary numbers to each of your goals can

\* Mr. Smith is a financial consultant with Merrill Lynch in Little Rock, Arkansas.



help you in this process. For example, according to Merrill Lynch, a four year college education at the University of Arkansas will cost approximately \$7,343 a year. Sixteen years from now the same education will cost approximately \$25,746 a year assuming a 7% rise in the cost of living annually.

If you are currently 36 years of age, and want to retire at 65, you can amortize these numbers forward to try and give a figure that you will need at retirement. Being able to live on \$35,000 at age 36 translates into a need of income of approximately \$140,000 at the age of 65 assuming a 5% inflation rate. (Remember, these numbers are assumptions and should only be used as a guideline). If you do not wish to amortize the numbers yourself, your financial advisor should be able to assist you in the process.

### Putting It All Together

After completion of the above analysis, you then should be able to determine what kind of investments will help you reach the desired goals you have set for yourself. You can now determine what percentage rate of interest you need to earn and how much additional savings is needed to reach your goal. This not only helps you to make sure you are on the right path, but helps you avoid taking unnecessary risks along the way.

In today's environment, there is more need for financial planning in order to assure a comfortable financial future.

*This is the third in a series of articles that will discuss the various steps for investing in the 90's.*



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\_\_\_\_ We already have a computer. It is: \_\_\_\_\_

\_\_\_\_ We do not have a computer.

We would like to computerize/upgrade:

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## ...To See Ourselves As Others See Us

Scott Berglund\*

Recently, a large settlement was made in favor of a patient who was initially denied treatment by her doctor's medical receptionist because the patient had a small past due balance with the doctor's office. The patient, 2 1/2 months pregnant, in process of miscarrying, was treated with rudeness and insensitivity by the receptionist in front of other waiting patients, and would have been turned away entirely had the physician not entered the waiting room, having heard the commotion, and agreed to treat the patient. The patient then left the doctor's office, unnoticed, through a side door after requesting to use the restroom. After returning home, the patient aborted the fetus, called one of her neighbors for help, and was transported, with the fetus, to the hospital by ambulance.

Even though there was no question about the viability of the fetus, and even though the patient left the office of her own accord without being treated, and aborted at home, the likelihood that a jury would award a sizable amount for "intentional infliction of mental distress" was extremely high. It is unfortunate, but true, that a doctor can be "torpedoed" by other members of the medical team as well as by his or her own actions. In the case noted above, the doctor, who was later called to the emergency room to see his patient, made the mistake of telling her that the miscarriage was not important since the fetus was "not a real baby but only a lump of tissue." Clearly, whether the fetus was a real baby or not, the words spoken by the doctor made an already terrible experience even worse for the patient. The doctor certainly did not realize that his words

would hurt the patient and lead to a settlement in excess of half a million dollars.

Understanding how we are perceived by others is very important in determining what we should say and how we should say it. It is often said that the world operates on perception not fact. This principle was pointedly taught at a communications seminar in which I was asked to participate.

At the seminar, which attracted doctors from several distant areas of the country, important discussions took place in which the participants analyzed many aspects of the doctor/patient relationship. As expected, almost every participant was able to contribute helpful hints on how to care for difficult patients. The event which followed, however, left an indelible and humbling imprint with everyone in attendance.

The doctors were divided into pairs, one to act as the physician and the other to act as a patient. The "patient" was given secret instructions as to how to conduct himself. These personality types included hostile and aggressive, completely loving and submissive, and almost completely withdrawn, and represented realistic patient types normally dealt with on a day to day basis. The general medical scenario for the conversation was explained and the pairs went to assigned areas of a large room to begin their conversations. At that moment, roving video tape crews began moving through the room recording these interviews. After the allotted time, the roles were reversed, the "patients" became the "doctors," and taping resumed.

That evening, armed with popcorn and other refreshments, I was assigned to lead the group in an informal, analytical discussion of each others' methods of dealing with the "patient" in the assigned video tape

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\* Mr. Berglund is the Risk Management Director at the American Physicians Insurance Exchange in Austin, Texas.



scenario. While the session began in good natured but somewhat self-conscious humor, words such as "devastating," "revealing," "enlightening," and "extremely shocked" were starting to emanate from all over the room. Clearly, each doctor's perception of how he or she had been communicating with patients was markedly different than the video segment the physicians had seen of themselves. The evening proceeded with much helpful and supportive discussion and the participants left the seminar with the resolve to greatly improve their methods of communicating with patients. Several of the physicians have written me to relate how they have changed certain methods of how they communicate with their patients and how it has helped their relationships.

What are these methods? Many aspects of communicating revolve around aspects of listening, and they start as early as the history and physical. By letting the patient explain feelings, history, background, etc., while you are gathering information, the patient's perception that you are a caring and sensitive person is well on its way to being established. It is not uncommon to find that some peripheral piece of information becomes useful later on in the doctor/patient relationship. Many doctors remember the "S.O.A.P." system taught at medical school: Subjective, Objective, Assessment, Plan. Several doctors stated they had forgotten how helpful the patient's "story" could be and found themselves often tuning out as the patients described their symptoms.

Even such nuances of communication as eye to eye contact, body language with open stances rather than folded arms, touching, looking at a clock because of a hurried schedule, all of these little things either add to or detract from a close and trusting relationship.

It is also not unusual for doctors to unwittingly frighten their patients by words and actions. In presenting clinical findings to a patient, for example, waiting for lab results without giving adequate information and assurance to the patient can leave them "twisting in the wind," often unnecessarily, because many diagnoses can be reliably given based on other findings.

Overwhelming the patient with technical jargon, no matter how well educated the patient seems to be, can also be disturbing. It's at the time when the patient's illness or condition is discussed that the patient is most worried and the doctor's sensitivity and empathy are most important. Even the prescribing of certain medications, such as nitroglycerin, can have a very upsetting effect. One patient went home and told his wife that he had been prescribed an "explosive" to treat his heart condition. In complete hysteria, she called the doctor, asking how in the world he would put their whole family in such jeopardy.

Other doctor/patient discussions concerning physical conditions such as angina, hypertension, potential

stroke, cancer and even rectal disorders needing proctosigmoidoscopic procedures can be devastating to the patient when not tactfully explained. These discussions, if not sensitively handled, can bring embarrassment, fear, anger and distress to the patient and can even be a significant factor in a malpractice claim being filed, with the physician scratching his or her head wondering how in the world such a thing could happen when they "didn't do anything wrong."

When performing any invasive procedure with the patient awake, such as lumbar punctures, care should be taken that the patient's fears be dealt with in advance. Step by step information can be given, helping the patient to anticipate and understand what is about to happen. Such matters as allowing others in the room to view certain procedures need also to be discussed with the patient beforehand.

A good doctor friend once related to me the distress caused a dignified elderly woman when, while on rounds, the conducting physician pulled away the woman's bedsheets and gown, without warning, to show the resident physicians the difference between the patient's first mastectomy and the vastly improved second procedure. Although the patient uttered not a word, as the group left the young resident noticed tears in the eyes of the woman, and he went back, held her hand for a moment, looked her in the eyes and offered a quiet, humble apology for the invasion of her privacy. From that episode, my doctor friend vowed never to forget his patients' personal feelings, no matter how busy he was.

Of course, the physician has to contend with the fact that not all patients are likeable. In fact, some are downright tough to deal with. Other than the option of terminating a relationship with a patient who seems completely impossible to get along with, a doctor will experience many different personality types. These patients will range from totally noncommittal and nonverbal, to openly hostile and aggressive. Somewhere in the middle is the patient who is a pleasure to treat. They are honest, open, responsible and willing to share in the partnership of informed consent.

After reviewing countless files where malpractice suits have been levied against physicians, one thing emerges over and over again. It is the principle that communication revolves around perception, not fact. The unfortunate outcome in medicine is the common denominator of malpractice claims and other disagreements between doctor and patient, but is not always the main reason the patient sues. Much of the time, the decision by the patient as to whether to sue or to seek other avenues for redress or remedy revolves primarily around how the patient perceives he or she has been treated by the physician. And very often the patient has made an attempt to resolve the matter with the doctor before seeking the assistance of an attorney.



As I speak around the country and attend seminars and workshops, I hear many doctors express their anger toward plaintiff attorneys, oppressive tort law and greedy patients. Many of them claim that a lack of communication skills or mistakes made by their staffs are certainly not grounds for malpractice suits. While all these complaints are valid, I am often prompted to tell one of my favorite stories, "The Scorpion and the Frog. It seems one day a scorpion approached a frog, sitting on the bank of a pond, and asked the frog to allow him to ride on the frog's back to the other side. To this the frog replied, "Are you crazy? I know we would get part-way across and you would sting me to death." "Now that would certainly be stupid," replied the scorpion. "If I did that we would both drown. I promise not to sting you. I give you my word." With that promise, the frog allowed the scorpion to climb aboard and the two started across the pond. About half-way across, the scorpion stung the frog, causing the onset of paralysis and certain death for them both.

As they began to sink beneath the surface the frog asked, "Why did you do such a stupid thing? Now we will both die." The answer was, "I'm a scorpion ... that's what scorpions do."

While tort reform, alternative dispute resolution, plaintiff attorneys paying defense costs when they lose, and several other solutions would improve the litigious climate which exists today, those physicians who wait for plaintiff attorneys to become more honest and understanding or for the system to correct itself are leaving themselves at risk. Any time spent, therefore, in learning better habits of communication and in better understanding how you are perceived by your patients will pay big dividends, whether it's the avoidance of a major malpractice suit or just the feeling that comes from knowing that you are trusted and respected by your patients. Sometimes these attempts to increase self awareness and sensitivity can be embarrassing or even a little painful, but the rewards are ultimately well worth the effort.



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2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

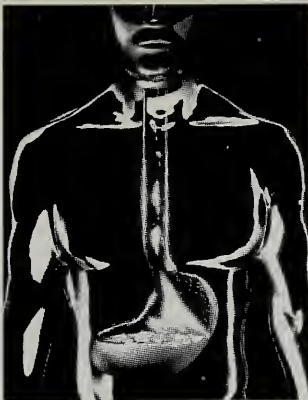
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# AMS Newsmakers

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**Dr. Joe Abrams**, a family physician from Cabot, has been appointed to the faculty of the University of Arkansas for Medical Sciences as an assistant clinical professor in the Department of Family and Community Medicine.

**Dr. Crit Cooksey**, a Little Rock psychiatrist, has been named director of the adolescent program at CPC Pinnacle Pointe Hospital in Little Rock.

**Dr. Bradley Diner**, a Little Rock psychiatrist, has been named president of the medical executive committee/chief of staff of CPC Pinnacle Pointe Hospital in Little Rock.

**Dr. Keith Dixon**, medical director of the Central Arkansas Dialysis and Transplantation Centers, has been elected second vice president of Goodwill Insurance of Arkansas Inc. in Little Rock.

**Dr. Leland Dodd**, a Hope pathologist and director of Medical Park Hospital's laboratory department, has received notification from the Commission on Laboratory Accreditation of the College of American Pathologists (CAP) that MPH's laboratory has been approved for a two-year accreditation based on a recent inspection.

**Dr. Vida Gordon**, a Little Rock pediatrician, received the Jerome Glaser Award at the annual meeting of the American Academy of Pediatrics and the Section of Pediatric Allergy and Immunology.

The award was given for "Outstanding Service" in the field of Pediatric Allergy and Immunology and to the Section on Allergy of the American Academy of Pediatrics. It is the first time that the award has been given to an allergist in Arkansas.

**Dr. Malcolm Hayward**, an oncologist and internist from Fayetteville, was elected chief of the medical staff at Washington Regional Medical Center for 1992-93.

**Dr. David C. Jacks**, a Pine Bluff urologist, was appointed to the Arkansas State Medical Board by Governor Bill Clinton.

**Dr. Samuel Landrum**, a general surgeon from Fort Smith, was named the recipient of Fort Smith Noon Exchange Club's 50th annual Book of Golden Deeds Award.

**Dr. John O. Lytle**, a Pine Bluff orthopaedic surgeon, was inducted as a fellow of the American Academy of Orthopaedic Surgeons.

**Dr. Michael Mackey**, a nephrologist from Jonesboro, was appointed by the Southern Medical Association as Associate Councilor for the State of Arkansas.

**Dr. Robert F. McCrary**, a nephrologist and internist from Hot Springs, was elected to fellowship in the American College of Physicians.

**Dr. James Pickett**, a urologist from Fayetteville, has been elected vice chief of staff at Washington Regional Medical Center for 1992-93.

**Dr. Gene Reid**, a Little Rock psychiatrist, has been named vice president of the medical executive committee of CPC Pinnacle Pointe Hospital in Little Rock.

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**Dr. Joe Rouse**, a family physician from Fayetteville, has been elected chairman of the Department of Medicine at Washington Regional Medical Center for 1992-93.

**Dr. Mitch Singleton**, an ophthalmologist from Fayetteville, has been elected chairman of the Department of Surgery at Washington Regional Medical Center for 1992-93.

**Dr. Robert Shannon**, a Little Rock psychiatrist, has been named medical director of CPC Pinnacle Pointe Hospital in Little Rock.

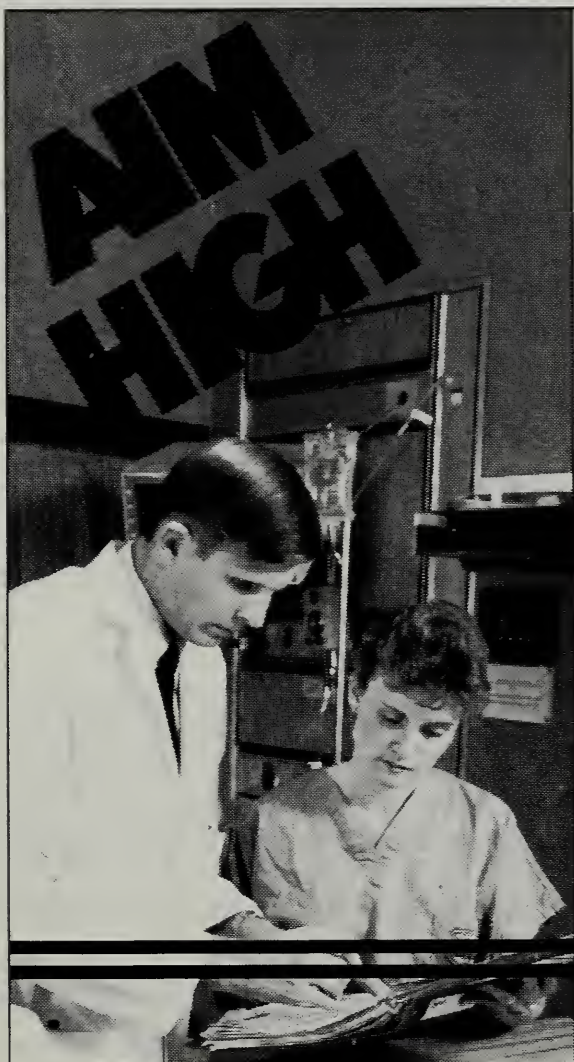
**Joseph S. Spades**, from Walnut Ridge, has been named the first recipient of the Arkansas State University Pre-Medical Alumni Scholarship. Mr. Spades is a junior zoology major in the pre-medical program of the College of Arts and Sciences at ASU. The Pre-Medical Alumni Scholarship provides \$1,600 over two semesters and is renewable provided the recipient maintains certain course load and grade point requirements. His parents are Dr. and Mrs. S.A. Spades of Walnut Ridge.

**Dr. Herd Stone**, a general practitioner from Holly Grove, retired recently after 44 years of service to the people of Holly Grove and the surrounding areas. A reception was held in his honor and a tribute was placed in the *Congressional Record* by Representative Bill Alexander.

The University of Arkansas College of Medicine announces its **Washington County Medical Society Scholarship** recipients for 1991-92. Each year the Society awards scholarships to outstanding students from Washington County. Students are recognized for their superior academic achievements and potential promise to become outstanding physicians.

The recipients for 1991-92 are: Deborah Hayes, Emily Hopkins, Terri Crook, Wade Ceola, Kevin Griffith, Nirmal Kilambi, David Conrow, John Mhoon, and Ketan Patel.

**Dr. James O. Wright**, a cardiovascular surgeon from Texarkana, has been elected to the board of directors of Wadley Regional Medical Center.



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# New Members

---

## ASHLEY COUNTY

**Beauchamp, Kermen D.**, Pediatrics, Crossett. Born, June 27, 1952, Mayaguez, Puerto Rico. Medical education, University of CADIZ, Spain, 1983. Internship, Mayaguez Medical Center, Puerto Rico, 1985. Residency, Ponce Regional Hospital, Puerto Rico, 1990.

## BOONE COUNTY

**Ashe, Barbara E.**, Emergency Medicine, Harrison. Born, January 4, 1958, New Orleans, LA. Medical education, Louisiana State University Medical School, New Orleans, 1984. Internship/residency, Charity Hospital, New Orleans, 1988.

## CRAIGHEAD/POINSETT COUNTY

**Young, Richard S.**, Pediatrics, Jonesboro. Born, January 26, 1959, Camp Walters, TX. Medical education, University of Texas Medical School, Houston, 1984. Internship/residency, University of Florida, 1987.

## HOWARD/PIKE COUNTY

**Sayre, John C.**, General Practice, Nashville. Born, May 18, 1947, Pawnee, OK. Medical education, Oklahoma University College of Medicine, Oklahoma City, 1976. Internship, Baptist Medical Center of Oklahoma, 1977.

## MILLER COUNTY

**Northam, Wanda M.**, Ophthalmology, Texarkana, TX. Born, August 31, 1961, Texarkana, AR. Medical education, University of Texas Medical School, San Antonio, 1987. Internship/residency, Tulane University Affiliated Hospitals, 1991. Board eligible.

**Tyler, Richard L.**, Family Practice, Texarkana, TX. Born July 30, 1958, Shreveport, LA. Medical education, Louisiana State University, Shreveport, 1985. Internship/residency, Roanoke Memorial Hospital, 1988. Board certified.

## POPE COUNTY

**Tapley, Thomas S.**, Pathology, Russellville. Born, June 2, 1953, Kennett, MO. Medical education, University of Mississippi, Jackson, 1978. Internship, Montgomery Family Practice, AL, 1979. Residency, Little Rock and Memphis. Board eligible.

## PULASKI COUNTY

**Bienvenu III, Harold G.**, ENT/Cosmetic Surgery, Little Rock. Born, July 7, 1953, St. Martinville, LA. Medical education, Louisiana State University, New Orleans, 1979. Internship/residency, UAMS, 1984. Board certified.

**Harter, Scott B.**, Radiology, Little Rock. Born July 4, 1958, Champaign, IL. Medical education, Louisiana State University, Shreveport, 1984. Internship/residency, North Carolina Baptist Hospital, Winston-Salem, 1991. Board certified.

## SEVIER COUNTY

**Dow, John T.**, Family Practice, DeQueen. Born, January 8, 1956, Ozark. Medical education, Oklahoma, 1982. Residency, University of Oklahoma, Tulsa Medical College, 1985. Board certified.

## UNION COUNTY

**Barenbug, Andrew H.**, Gastroenterology/Internal Medicine, El Dorado. Born, July 7, 1959, Albany, NY. Medical education, University of Texas Medical Branch, Galveston, 1986. Internship/residency, Texas Tech University Health Sciences Center, Lubbock, 1989. Board certified.

## WHITE COUNTY

**Rutherford, Reginald F.**, Neurology, Searcy. Born, March 10, 1952, Toronto, Canada. Medical education, Queens University, Kingston, Ontario, Canada, 1978. Internship, Sunnibrook Medical Center, Toronto, 1979. Residency, Toronto Neurology Program, 1983. Board certified.

## MEMBERS-AT-LARGE

### *Hot Springs*

**Fine Jr., Bobbie D.**, Nephrology/Hypertension. Born, May 11, 1959, Rogers. Medical education, Oral Roberts University School of Medicine, Tulsa, 1985. Internship, University of Oklahoma, Tulsa, 1987. Residency, University of Illinois, Peoria, 1989. Board certified.

**James, Janeen H.**, General Surgery. Born February 13, 1950, Odessa, TX. Medical education, University of Texas Health Science Center, San Antonio, 1982. Internship/residency, University of Texas Health Science Center, San Antonio, 1987.



### **Jonesboro**

**Edgerton, Ada B.**, Ophthalmology. Born, April 13, 1947, Louisville, KY. Medical education, Columbia College of Physicians of Surgeons, New York, NY. Internship, Lenox Hill Hospital, 1979. Board certified.

**Marzewski, David I.**, Neurology. Born, March 30, 1948, Philadelphia, PA. Medical education, Hahnemann University, Philadelphia, 1974. Internship/residency, Geisinger Medical Center, 1978. Board certified.

**Stank, Thomas M.**, Ophthalmology. Medical education, Pennsylvania State University, Hershey, 1985. Internship, York Hospital, 1986. Residency, University of Pennsylvania, 1989.

### **Little Rock**

**Flaming, Jay A.**, Dermatology. Born, March 18, 1962, Tulsa, OK. Medical education, University of Oklahoma College of Medicine, Oklahoma City, 1988. Internship, UAMS, 1989. Residency, University of Oklahoma College of Medicine, 1992. Board eligible.

### **Nashville**

**Patel, Madanmohan R.**, Internal Medicine. Born, April 5, 1963, India. Medical education, Shree M.P. Shah Medical College, Jamnagar, Gujarat, India, 1986. Internship/residency, Bronx Lebanon Hospital Center, New York, NY, 1991.

### **Springdale**

**Bailey, Donald C.**, Orthopaedic Surgery. Born, March 30, 1937, Oklahoma City. Medical education, University of Oklahoma, Oklahoma City, 1961. Internship, St. Anthony, Oklahoma City, 1966. Residency, Wichita, KS, 1970. Board certified.

## **RESIDENT PHYSICIAN SECTION**

**Crosby, John C.**, Anesthesiology, Little Rock. Born, August 5, 1964, Gainesville, FL. Medical education, Louisiana State University School of Medicine, Shreveport, 1990. Internship, Louisiana State University School of Medicine, Shreveport. Residency, UAMS.

**Langston, James D.**, General Surgery, Little Rock. Born, September 4, 1958, Little Rock. Medical education, UAMS, 1988. Residency, UAMS.

**Whitley, Brent J.**, Family Practice, El Dorado. Born, April 23, 1956, Summit, NJ. Medical education, Spartan Health Science University, Vieux Fort, St. Lucia, 1987. Internship, Jersey Shore Medical Center, Neptune, NJ. Residency, AHEC-El Dorado.

## **MEDICAL STUDENT SECTION**

Leonard, Stacy L.

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The members of the Order of Merit set the example for their colleagues, orthopaedic industry and the public. They demonstrate the power of philanthropy in expanding knowledge in orthopaedics for the relief of human suffering. Following is the Arkansas Roster of the 1991 Members, including all orthopaedists from Pine Bluff which has, thereby, been designated a "City of Merit."

- *Banks Blackwell, M.D., Medical Director* -

James A. Arnold, M.D., Fayetteville  
Mr. Michael M. Bailey, Little Rock  
Banks Blackwell, M.D., Pine Bluff  
(A Memorial Tribute to Lyman Smith, M.D.)  
Charles A. Clark, M.D., Pine Bluff  
Robert R. Gullett, Jr., M.D., Pine Bluff  
(A Memorial Tribute to Richard LeBlanc, M.D.)  
Dr. & Mrs. Peter J. Irwin, Fort Smith  
Philip H. Johnson, M.D., Little Rock  
Dr. & Mrs. James M. Kolb, Jr., Russellville  
Dr. & Mrs. Charles A. Ledbetter, Harrison  
(A Tribute to Donald B. Kettelkamp, M.D.)  
John O. Lytle, M.D., Pine Bluff  
Dr. & Mrs. Bruce L. Smith, Jr., Hot Springs  
J. L. Vander Schilden, M.D., Little Rock  
(A Memorial Tribute to Richard Webber, Ph.D.)



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 CHARGE SLIPS HMO WRITE-OFF  
 CURRENT PROCEDURAL TERMINOLOGY  
**OUTSIDE LAB CHARGES**  
**SUPERBILL PPO**  
 WORKMAN'S COMP  
 ICD DIAGNOSIS CODES  
 REFERRING PHYSICIAN SECONDARY  
 GROUP NUMBER **HICFA**  
 PLACE OF SERVICE CODE  
**PRIMARY CARRIER**  
 PRIOR AUTHORIZATION  
 TYPE OF SERVICE CODES  
 SAME/SIMILIAR INDICATOR  
 PATIENT CHARTS DAY SHEETS  
**SUPERBILL**  
 CPT PROCEDURE CODES  
 WAITING **LEDGER CARDS** WRITE-OFF PARTICIPATING PHYSICIAN  
 ROOM INSURANCE CARDS GROUP PLOICY NUMBER CHARGE SLIPS **MEDICARE**  
 DISABILITY PATIENT STATEMENTS RELATIONSHIP TO THE INSURED PAYMENT  
**APPROVED AMOUNT** TYPEWRITER  
 APPOINTMENT BOOK EXAMINATION ROOM TICKLER FILES **DATE OF DISABILITY**  
 SELF PAYS MEDICAID ATTENDING PHYSICIAN PPO/HMO  
 DATE OF ACCIDENT **PATIENT RECORDS** RESPONSIBLE PARTY  
 INDIVIDUAL POLICY NUMBER

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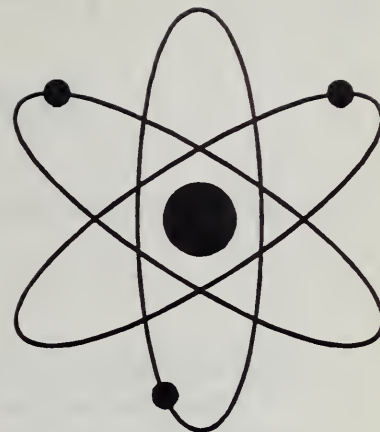
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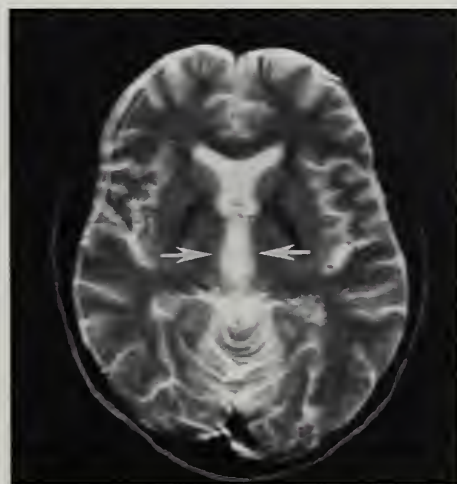
# Radiological Case of the Month



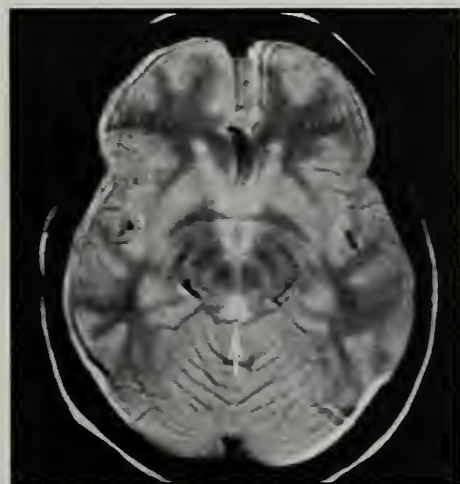
W. Bradley Pierce, M.D.  
Beverly A. Beadle, M.D.  
Charles D. Barg, M.D.  
Steven R. Nokes, M.D.



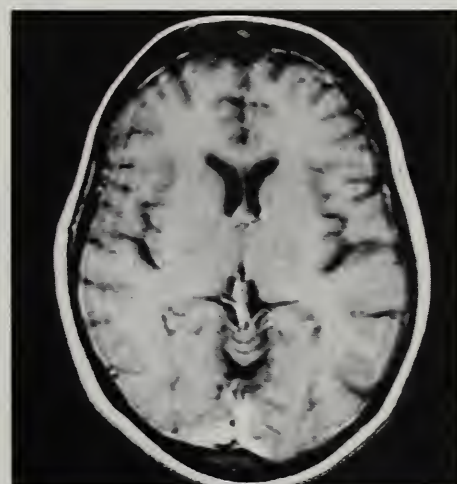
*Figure 1a. Axial proton-density weighted image at the level of the third ventricle and thalami.*



*Figure 1b. Axial T2-weighted image.*



*Figure 2. Axial proton-density weighted image at the level of the aqueduct.*



*Figure 3. Axial post-infusion T1-weighted image at the same level as 1a and 1b.*

## History:

This 65-year-old female presented with confusion and dizziness. Physical examination revealed nystagmus and medial gaze paralysis.



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# Wernicke Encephalopathy

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## Radiographic Findings:

Hyperintense areas (arrows) surround the third ventricle and aqueduct on proton-density and T2-weighted images (Figures 1a, 1b, and 2). These are best seen on the proton-density weighted images due to the high signal intensity CSF on T2-weighted images. No enhancement is seen on the post-infusion scan (Figure 3).

## Discussion:

Wernicke encephalopathy is caused by deficiency of thiamine, most often occurring in alcoholics. It may also be seen in patients with prolonged febrile illnesses, carcinoma, anorexia nervosa, and in patients on prolonged hyperalimentation.

The classical clinical triad of ophthalmoplegia, ataxia, and confusional state is only found initially in one-third of patients. The ocular signs and ataxia may improve after only a meal or two in the hospital and patients may deny excessive alcoholic intake (as in this case). If not recognized and treatment with parenteral thiamine is not promptly instituted, the disease may progress to coma and death. Treatment will partially or completely eliminate the symptoms, depending on their duration prior to diagnosis.

Histologically, lesions characterized by edema, demyelination, and necrosis are found in a symmetric distribution surrounding the third ventricle, in the periaqueductal region, and in the mamillary bodies.

MR allows early diagnosis of Wernicke encephalopathy and demonstrates characteristic bilaterally symmetric periaqueductal and periventricular (medial thalamic) foci of increased signal intensity. With treatment these areas of hyperintensity will resolve with development of third ventricular and aqueductal dilatation and atrophy of the mamillary bodies.

The symmetry of these foci and their characteristic location permit differentiation from other periventricular disease processes.

## References

1. Gallucci M, Bozzao A, Splendiani A, Masciocchi C, Passariello R. Wernicke encephalopathy: MR findings in five patients. *AJR* 1990; 155:1309-14.
2. Donnal JF, Heinz ER, Burger PC. MR of reversible thalamic lesions in Wernicke Syndrome. *AJNR* 1990; 11:893-4.
3. Victor M. MR in the diagnosis of Wernicke-Korsakoff Syndrome. *AJR* 1990; 155:1315-16.

---

*Editor: Steven R. Nokes, M.D., is director of CT/MRI for Radiology Consultants in Little Rock.*

*Contributor: W. Bradley Pierce, M.D., is affiliated with Radiology Consultants in Little Rock.*

*Contributor: Beverly A. Beadle, M.D., is affiliated with Neurology Associates in Little Rock.*

*Contributor: Charles D. Barg, M.D., is affiliated with the Family Practice Clinic in Little Rock.*



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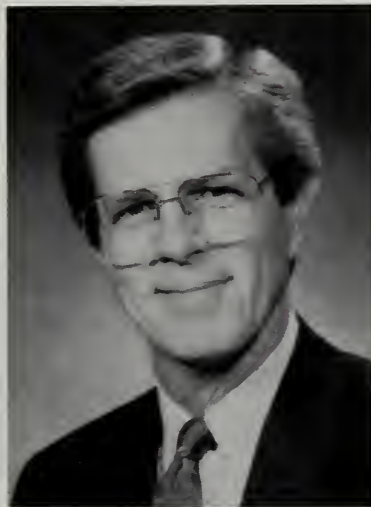


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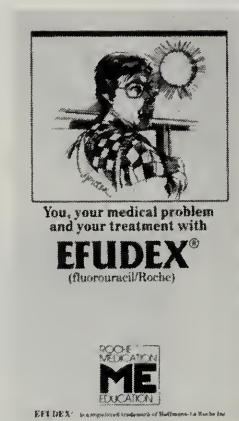
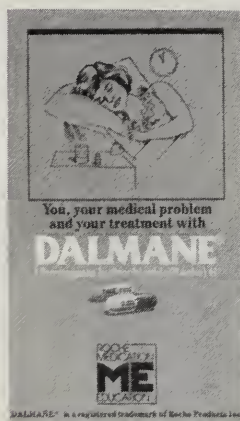
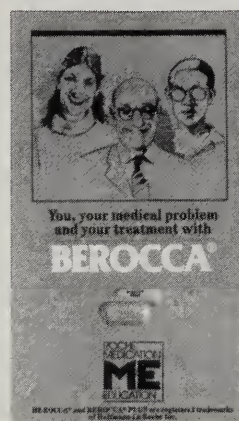
John D. Sagely, Jr.



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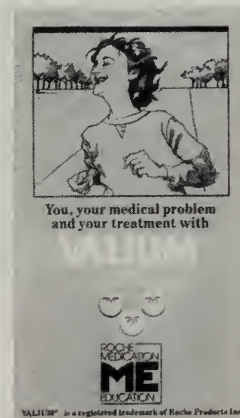
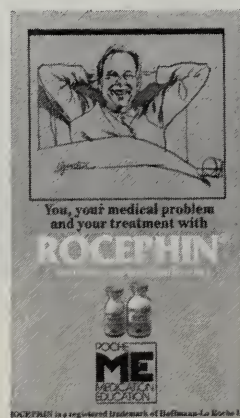
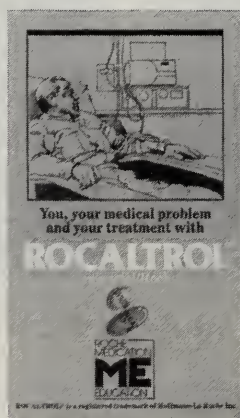
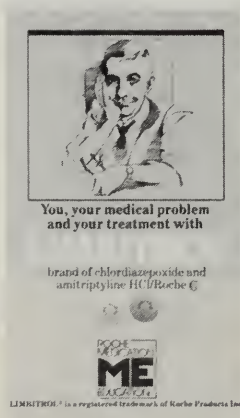
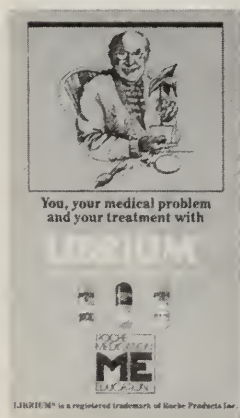


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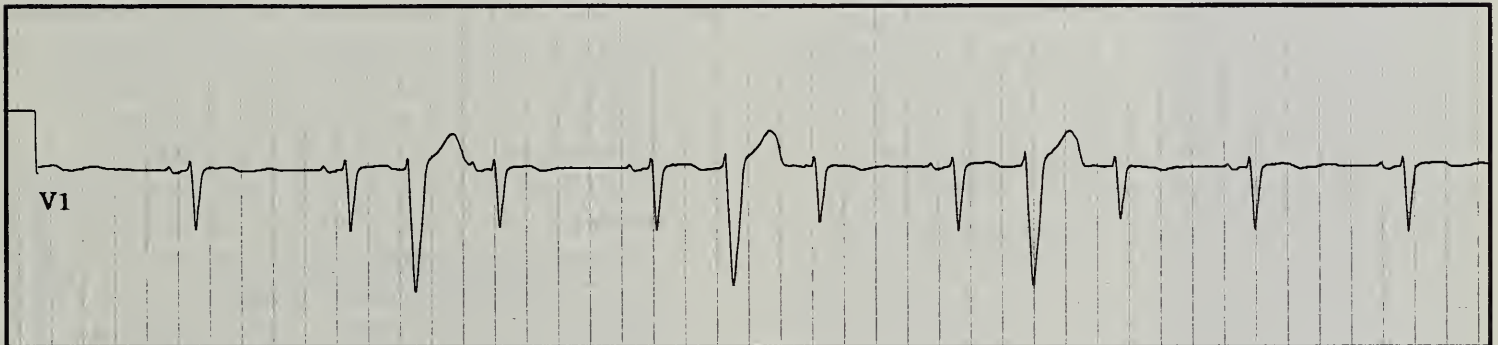


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## HISTORY:

This record was obtained from a 84-year-old woman recovering from digitalis excess. *Get your calipers out!*



## DISCUSSION:

Sinus rhythm is present with normal AV and intraventricular conduction. Three premature ventricular complexes (PVC) are present. Because the supraventricular (sinus) impulses which follow the PVC's are conducted, the PVC's are called interpolated. More commonly, the PVC is conducted retrogradely via the His-Purkinje system to the AV node. Depolarization of the AV node renders the AV node refractory to the following sinus impulse, resulting in a failure of conduction. This is the mechanism underlying the compensatory pause. This record manifests a phenomenon intermediate between the two. Specifically, if the regular sinus PP interval is examined, it is evident that a normal sinus P wave is superimposed on the T wave of the second and third PVC's. By estimating the location of the P wave in the T waves and measuring the PR interval of the complex following the PVC, it is evident that the PR interval following the second or third PVC is prolonged. This can be confirmed by comparing the RR intervals of the conducted QRS's surrounding the second and third PVC's with the RR interval of the following two consecutive sinus complexes. The RR intervals surrounding the PVC's are longer. The effect of the PVC on the following PR interval is termed concealed conduction. Although there is no electrical evidence of depolarization of the AV node by retrograde conduction of the PVC, its existence is proven by the effect of the PVC on the returning cycle. Hence the term, concealed conduction. There is one additional interesting observation. The PR interval of the early sinus complex following the first PVC is normal, in contrast to those following the subsequent PVC's. This is because the RP interval (the interval between the onset of the PVC and the following P wave) is longer than the RP interval following the two subsequent PVC's. This is a manifestation of the RP-PR relationship. The RP-PR relationship is a manifestation of normal AV nodal function and states that the shorter the RP, the longer the PR. The converse also holds.



# Medicine in the News

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## Health Care Access Foundation Update

As of March 1992, the Arkansas Health Care Access Foundation has provided free medical services to 3,617 medically indigent persons.

The program has 1,460 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## Arkansas State Medical Board Minutes

The Arkansas State Medical Board met on December 12 and 13, 1991. Actions and a summary of that meeting follows:

- Norman Pledger, M.D., medical director of the Cardiovascular Testing & Life Style Center in North Little Rock appeared before the Board in response to an Order and Notice of Hearing ordered at the September 1991 Board meeting. Dr. Pledger was found in violation of the Medical Practices Act, Arkansas Code, Annotated Sec. 17-93-409 (13b); more especially, advertising for patronage in a false, fraudulent, deceptive or misleading manner and Section 17-93-409 (16), that is the persistent over-treating of patients. The Board further voted to accept an agreement proposed by Dr. Pledger, in lieu of punishment. The agreement is as follows: "to be observed by the Arkansas State Medical Board and/or its investigators for a period of one year; to no longer permit a nurse practitioner or order diagnostic testing for patients without himself or a physician seeing said patient, and will incorporate said policy into his practice, both the family practice and the Cardiovascular Testing & Lifestyle Center, and in a reasonable time, will refrain from participation after the 15th day of January 1992, in the Cardiovascular Testing & Lifestyle Center, other than training, which will included informing the new medical director of the correct procedures and protocols and of the contents of the Order, and will, in a reasonable time, divest himself of the ownership interest in said Cardiovascular Testing & Lifestyle Center."
  - The requests of Drs. James Sykes of Paragould and John Ferguson of Sherman, Texas, for permission to reapply for the DEA numbers was granted. One Order to Show Cause was issued for the March 12th meeting.
  - Licenses to practice were issued to 60 physicians. Two physicians, Dr. David G. Yahnke and Dr. Fouad M. Rabie, were denied licensure. Dr. Yahnke remains on probation in Indiana, but can reapply at the conclusion of that probation. Dr. Rabie will be required to pass the SPEX exam and complete a one month OB/GYN preceptorship at UAMS before his application can be reconsidered. Ninety-five temporary permits were issued to physicians who have permanent applications in process.
  - The Board reviewed 27 complaints made against individual physicians and discussed the practice habits and procedures of 14 others. Letters of reprimand were written to five physicians.
  - A public hearing to consider a regulation governing the licensing and practice of Occupational Therapy was held on December 12th. With no objections, the following regulation passed. "Regulation No. 2.3: PASSING SCORE. The Board shall accept as the standard for acceptable performance for each examination, that score designated as passing by the American Occupational Therapy Certification Board. Applicants may obtain their examination scores in accordance with such rules as the American Occupational Therapy Certification Board may establish, upon approval of the Board."
  - Mr. John Currie Sr., of Wilmot, was elected to serve as Treasurer. The following meeting and hearing dates were scheduled for 1992. March 12 & 13, June 11 & 12, September 17 & 18, and December 10 & 11.
  - With great hesitation, the Board accepted the resignation of Dr. Jim Lytle of Batesville, who has served on the board since 1986. Dr. Lytle's commitment of the Board will be missed.
- ## OPSF Awards Scholarships
- The Occupational Physicians Scholarship Fund (OPSF) has awarded one-year scholarships totaling \$356,000 to 12 physicians who plan to enter the field



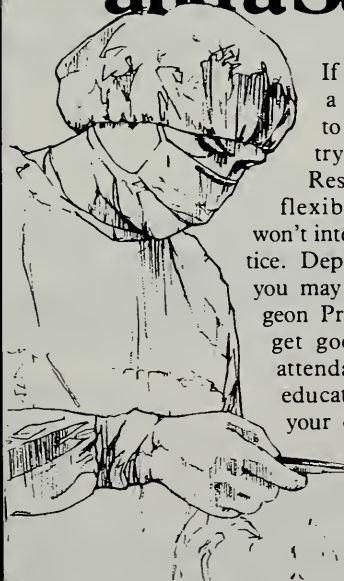
of occupational medicine. Scholarships with a value of \$25,000 to \$35,000 each are granted strictly on merit.

The OPSF scholarship, based on federal stipend levels appropriate for years of training, is awarded upon a physician's acceptance into an accredited occupational residency program to complete his or her academic and/or practicum years.

Corporations and individuals have contributed more than \$4.3 million to the fund since its inception in 1987 in an effort to attract physicians to the field of occupational medicine.

Deadline for scholarship applications for the 1993-94 academic years is November 13, 1992. Complete information about the scholarships is available from the Occupational Physicians Scholarship Fund, 55 West Seegers Road, Arlington Heights, IL, 60005.

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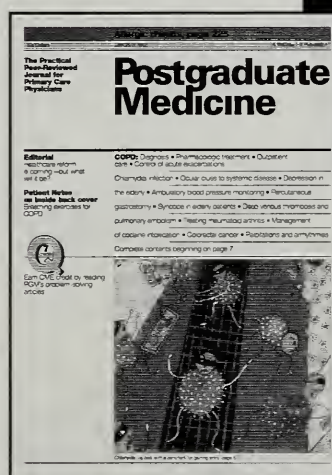
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# Things To Come

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## **April 22-26**

**Symposium on Management of Common Infections in Practice; 12th Annual National Pediatric Infectious Disease Seminar; and Special Session on Risk Management in the Pediatric Office.** Grand Hyatt Hotel, Washington, D.C. Sponsored by the Department of Pediatrics, Southwestern Medical School, The University of Texas Southwestern Medical Center. Fees: \$350; \$250, residents, fellow, PA's and PNP's. AMA Category I, AAFP, and PREP credits available. For more information, contact Marian Troup at (214) 688-8845.

## **April 22-26**

**6th Annual Critical Care Update.** Hyatt Regency-Capitol Hill, Washington, D.C. Co-sponsored by the Society of Critical Care Medicine, Rush Presbyterian-St. Luke's Medical Center, in cooperation with the Critical Care Medicine Department of the Clinical Center of the National Institutes of Health. Category I credits available. For more information, contact Svetlana Lisanti at (201) 385-8080.

## **April 24-25**

**5th Hearing Aid Conference.** The Clarion Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## **April 27- May 1**

**25th National Conference on Breast Cancer.** The Westin Hotel, Copley Place, Boston, Massachusetts. Sponsored by the American College of Radiology.

## **May 2-4**

**18th Annual Meeting of the Federated Ambulatory Surgery Association.** The Boston Marriott, Copley Place. For more information, call (703) 836-8808.

## **May 5**

**Surgery in the Developing World.** The Royal Society of Medicine, London, England. For more information, contact Keith Newton at The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE.

## **May 7-9**

**2nd Annual Cardiovascular Disease Review & Update.** Hotel Inter-Continental, Chicago, IL. Sponsored by the Rush Heart Institute, Section of Cardiology, Department of Cardiovascular and Thoracic Surgery, Rush Presbyterian - St. Luke's Medical Center. Category I credits offered. For more information, contact Svetlana Lisanti at (201) 385-8080.

## **May 15-16**

**Advanced Laparoscopy for the General Surgeon.** Wohl Auditorium, Washington University Medical Center, St. Louis, MO. Sponsored by the Washington University Medical Center. Course is limited to 18 registrants. For more information, contact Cathy Caruso at 1-800-325-9862.

## **May 15-17**

**Positron Emission Tomography.** Hilton, Walt Disney World Village, Lake Buena Vista, Florida. Sponsored by the American College of Radiology. For more information, contact Kathy Lawrence at 1-800-227-5463 ext. 4961.

## **June 4-7**

**Advances in Aesthetic & Reconstructive Breast Surgery.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## **June 11-13**

**Cornea & Contact Lens Conference.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## **June 26-28**

**Frontiers in Endourology.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.



### June 29-July 3

**Origins of Coping with Stress.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 6-10

**Behavioral Medicine Applications.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 13-17

**Psychopharmacology Update.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 13-17

**Multiple Family Group Therapy for Abuse.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 20-24

**Personality and Political Behavior.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

### July 27-31

**Learning Disorders in Childhood and Adolescence.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

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# Keeping Up

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## **9th Annual Arkansas Chest Symposium**

May 2-3, Inn of the Ozarks, Eureka Springs. Sponsored by the American Lung Association of Arkansas. For more information, call David Cook, American Lung Association, 1-800-880-5864, or Alicia Pierce, UAMS, (501) 686-5261.

## **Arkansas Hand Club Annual Meeting**

May 8-9, 1992, Gaston's White River Resort, Lakeview. For more information, contact Nadine Gentry at (501) 224-8967 or 1-800-542-1058.

## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.

### **FAYETTEVILLE - VA MEDICAL CENTER**

Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC  
Medical Grand Rounds, Fridays, 12:00 noon, VAMC

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium  
Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457  
Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom  
Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium  
Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom  
Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom  
Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided  
Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served  
Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided  
GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided  
Sleep Disorders Case Conference, every other Thursday, Sleep Disorders Center conference room. Lunch provided  
Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1  
GI Conference, 4th Friday, 12:00 noon, conference room 1  
Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library  
Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided.  
Category 1 credits available.  
Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided  
Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided

### **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room  
Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room



*Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room*  
*X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room*

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits*  
*Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B*  
*Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B*  
*Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock*  
*Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06*  
*Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06*  
*CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy*  
*Cardiothoracic Surgery Conference, date, time, & location varies*  
*Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D*  
*Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D*  
*Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room*  
*CME Outreach Program, dates, times & locations vary*  
*Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B*  
*Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B*  
*Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B*  
*Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B*  
*Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room*  
*Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29*  
*GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293*  
*Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room*  
*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room*  
*LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month*  
*LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC*  
*Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B*  
*Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306*  
*Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room*  
*Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135*  
*Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH*  
*Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours*  
*Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293*  
*Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33*  
*Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C*  
*Neruosurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours*  
*Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141*  
*OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.*  
*OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B*  
*Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours*  
*Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102*  
*Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135*  
*Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours*  
*Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135*  
*Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135*  
*Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue*  
*Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium*  
*Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room*  
*Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room*  
*Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room*  
*Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room*  
*Trauma Morbidity & Mortality Conference, date & time varies monthly, ACRC 2nd floor conference room*  
*Urology Adult Subject Oriented Conference, once monthly, 5:00 p.m., VAMC-LR, 4D*



*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## **FORT SMITH - AHEC**

*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom  
*Tumor Conference*, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided



Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria  
White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom

### **PINE BLUFF-AHEC**

*Behavioral Science Conference*, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center  
*Chest Conference*, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center  
*Family Practice Conference*, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Geriatrics Conference*, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center  
*Internal Medicine Conference*, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Obstetrics/Gynecology Conference*, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Orthopedic Case Conference*, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.  
*Pediatric Conference*, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center  
*Radiology Conference*, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center  
*Southeast Arkansas Medical Lecture Series*, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.  
*Surgery Conference*, 1st Friday, 12:00 noon, Jefferson Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center

### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference*, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.  
*Internal Medicine Conference*, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center  
*Neuro-Radiology Conference*, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center  
*Surgeons Pathology Conference*, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center  
*Tumor Conference*, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital  
*AHEC Tumor Board*, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital

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Herb Walters & Associates, Inc. ....	568
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Medical Protective Company .....	562
<i>Ferguson Advertising, Inc.</i>	
MEDX .....	587
Metropolitan National Bank .....	574
Orthopaedic Research & Education Foundation .....	577
Orthopaedics .....	561
<i>Comp-Art of Louisville, Inc.</i>	
Palisades Pharmaceuticals .....	557
<i>Design and Advertising</i>	
Parke Davis .....	insert
<i>Thomas G. Ferguson Associates, Inc.</i>	
Postgraduate Medicine .....	585
Radiology Consultants .....	552
Rather, Beyer & Harper .....	561
Riverside Motors, Inc. ....	549
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Roche Laboratories .....	581/582
<i>Bryan, Brown &amp; Malinsky</i>	
State Volunteer Mutual Insurance Company .....	550
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### MANUSCRIPT STYLE

Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

Along with the typed manuscript, we encourage you to submit an IBM-compatible 5 1/4" floppy diskette containing the manuscript. The manuscript on diskette must be in the same format as stated above. We will return the diskette upon request.

### REFERENCES

References should be limited to ten; if more than ten are listed, the author(s) may designate the ten most significant to be printed and readers will be referred to the authors(s) for the complete list. References must contain, in the order given: name of author(s), title of article, name of periodicals with volume, page, month and year. References should be numbered consecutively in the order in which they appear in the text. Authors are responsible for reference accuracy.

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For the many faces of mild hypertension



## THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION<sup>1\*</sup>

- Effective 24-hour control<sup>2</sup>
- Single-agent efficacy
- Well tolerated<sup>3</sup>
- No adverse effects on total cholesterol, plasma glucose levels, renal function,<sup>4</sup> or serum electrolytes<sup>3-6</sup>



For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digitoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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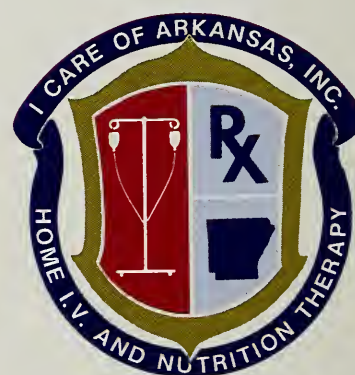
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# AXID<sup>®</sup> nizatidine capsules

**Brief Summary.** Consult the package insert for complete prescribing information.

**Indications and Usage:** 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

**Contraindication:** Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H<sub>2</sub>-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H<sub>2</sub>-receptor antagonists.

**Precautions:** *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

**Laboratory Tests**—False-positive tests for urobilinogen with Multistix<sup>®</sup> may occur during therapy.

**Drug Interactions**—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

**Carcinogenesis, Mutagenesis, Impairment of Fertility**—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

**Pregnancy—Teratogenic Effects—Pregnancy Category C**—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers**—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

**Pediatric Use**—Safety and effectiveness in children have not been established.

**Use in Elderly Patients**—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

**Adverse Reactions:** Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

**Hepatic**—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

**Cardiovascular**—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

**CNS**—Rare cases of reversible mental confusion have been reported.

**Endocrine**—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

**Hematologic**—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H<sub>2</sub>-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

**Integumental**—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

**Hypersensitivity**—As with other H<sub>2</sub>-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

**Other**—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

**Overdosage:** Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

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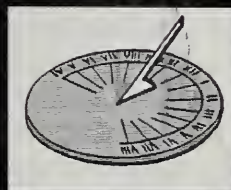
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**Postgraduate Medicine**

**Editorial**  
Highlights inform  
a coming-out event  
with Lip

**Patient Notes**  
on stroke back cover  
Breathing apparatus for  
COPD

**COPD:** Diagnosis • Pharmacologic treatment • Outpatient  
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gastroscopy • Sclerotherapy in elderly patients • Deep venous thrombosis and  
pulmonary embolism • Treating rheumatoid arthritis • Management  
of cocaine addiction • Cervical cancer • Reproductive and amniotic  
Connective tissue disorders (page 7)

**PSY**  
Can CME credit be earned  
from this problem-solving  
article?

*Continued on page 7*

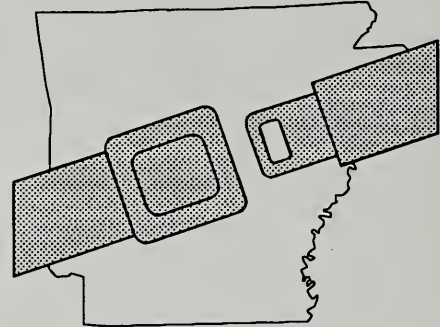
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## 70% by '92



Ben N. Saltzman, M.D.

**S**ummer is approaching. The three summer holidays, Memorial, Independence, and Labor Days with the concomitant increase in automobile travel on our roads and highways, should cause us to stop and think about the question of traffic safety.

The National Safety Belt Coalition, consisting of private and public groups in partnership with the National Highway Traffic Safety Administration has been established to support and publicize a National "70% by '92" Safety Belt Program. This statistical program title derives from the following general statistics:

- 6.7 million motor vehicle crashes are reported by the police each year.
- More than 15 million people and 11 million vehicles are involved in these crashes.
- About 42,000 deaths result from these crashes; that's an average of 115 deaths per day (similar to a major airline crash every day of the year).
- 25,000 passenger car occupants die every year (1985-1989). That's about 3,300 more than the total number of homicides that occur in the U.S. each year.
- Motor vehicle crashes are the leading cause of deaths for persons aged five to 32.
- Annual cost to society of motor vehicle crashes is more than \$74 billion (annual cost of crime is \$14 billion).
- Lap-shoulder belts are 40-50% effective in reducing deaths and 45-55% in preventing moderate-to-critical injuries to passenger vehicle occupants.
- In 1990, if every front seat occupant had buckled up, an estimated 15,275 deaths and several hundred thousand serious injuries could have been prevented.
- In 1990, 100% use of child safety seats could have prevented nearly 500 deaths and about 49,000 serious injuries to children under age five.
- Without safety belt laws, the U.S. was unable to achieve use rates higher than 15%.
- With passage of laws in 41 states, the District of Columbia and Puerto Rico, the national use rate reached 60% in 1991, spurred by the National "70% by '92" Safety Belt Program.
- Belt use in states with a law is generally 50% higher than rates in non-law states.
- Use rates above 50% are seldom reached without emphasizing belt law enforcement and publicity about the need for enforcement.
- At the use rates achieved through 1990, safety belts have reduced occupant deaths by about 14%.
- California, Oregon and Maryland have shown that well-publicized enforcement can produce use rates at 70% or above; Hawaii has reached 85%.



- Canada boosted use rates in some provinces from 55% to over 90% by conducting special enforcement programs.
- Public opinion surveys reveal that 88% of respondents believe belts save lives and reduce injuries; 75% say they favor belt use laws; 70% say the risk of receiving a citation would make them buckle up; 65% (in law states) say police should issue more citations—but almost one-half still fail to buckle up.

Arkansas now has a seat-belt law. However, we have not yet achieved perfection.

In the fall of 1989, at the behest of the American Academy of Family Physicians and the Arkansas Chapter, I attended a course entitled "Prevention of Motor Vehicle Trauma." This was followed by a course entitled "Patient Education: A Family Affair." The first related to the importance of the use of seat-shoulder belts and the second stressed the importance of the physician in educating the patient and the family in the use of preventive measures to preserve health.

We have been told repeatedly that the physician is the highest authority in the field of health care. We have accepted that designation, but we have not always practiced the responsibility associated with it. The question, "Do you buckle up?" should be part of every physical examination, no matter what the speciality. If stressed often enough, the patient or the family of the patient will come to recognize that we are serious and that we mean it. Person to person contact is the most effective form of communication. We can and must take that responsibility.

The use of air bags in motor vehicles is an important development, but seat belts are necessary for them to be effective in a lateral or in head-on crashes. Besides, it will be some time before they will become standard equipment in all vehicles on the road. Meanwhile, let us concentrate on the task of saving lives and preventing suffering by preventing needless injury. In the words of James Bryce spoken almost 80 years ago, let us remain "...the only profession that labors incessantly to destroy the reason for its own existence."

*Statistical information provided by the National Safety Belt Coalition.* ■



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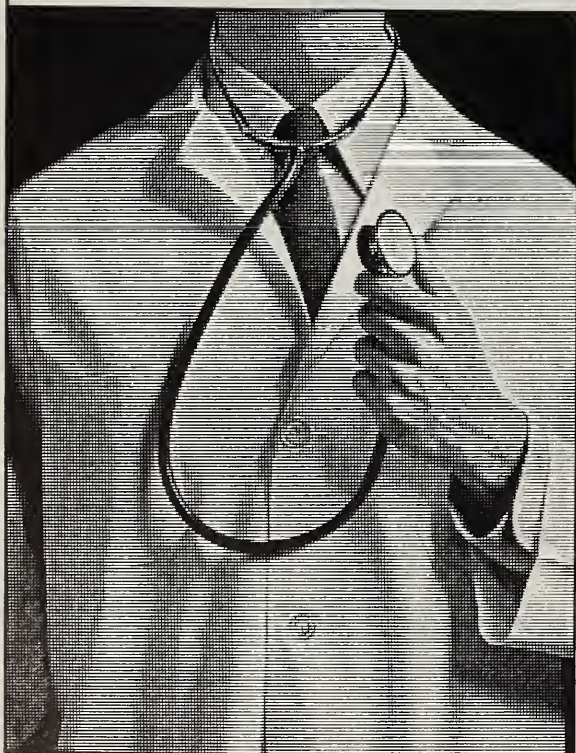
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# Involvement of Arkansas Hospitals in Promotion of Car Restraint Device Use Among Young Children

Robert West, M.D.\*  
Christie Robinette\*\*

*Child restraint devices are a proven means of reducing automobile-related deaths and injuries among infants and toddlers. To determine the role that Arkansas hospitals play in promoting use of these devices, a survey similar to one conducted previously in Tennessee was performed of hospitals providing newborn and/or pediatric services. Hospital policies relating to discharge of patients in car restraints were more likely to pertain to newborns than to older children. Nearly all the facilities having such policies claimed that these were strictly enforced. Hospitals are encouraged to establish discharge policies and to expand educational efforts and loaner programs.*

**M**otor vehicle-related injuries remain the leading cause of death in infants and children over the age of six months. Child restraint devices (safety seats) have repeatedly proven to be an effective means of reducing mortality and morbidity from this cause. The most commonly cited figures suggest that proper use of restraint devices is 71% effective in preventing death and 67% effective in preventing serious injury to young children involved in motor vehicle crashes.<sup>1</sup>

All 50 states and the District of Columbia have legislation requiring children to be restrained in approved safety seats. The Arkansas law, passed in 1983,

mandates safety seat usage up to the age of three, and either safety seats or safety belts for children three to five. Enforcement of the law is primary rather than secondary, which means that drivers may be stopped and ticketed simply for transporting an unrestrained child.

Unfortunately, despite the existence of this law, motor vehicle occupant deaths and injuries to children 0-4 years old have not significantly decreased in Arkansas during the past eight years (Table 1). While car seat usage rates have gradually improved during that time, the latest estimate of 54% usage during 1991 still lags far behind the national rate of 83%.<sup>2</sup>

Since virtually all Arkansas births occur in hospitals, these facilities should be in an excellent position to promote car seat usage for all infants. A 1986 survey of Tennessee hospitals (performed eight years after the passage of that state's restraint law) found that 26% of hospitals providing obstetric services had policies requiring discharge of newborns in safety seats, whereas only 5% of hospitals serving older children (less than 5 years) had safety seat discharge policies pertaining to that age group.<sup>3</sup> In addition, enforcement of existing policies was quite lax, with a full 64% of hospitals with policies reporting that these were completely waived if the parents could not produce a seat at the time of discharge. Using a survey tool very similar to that of the Tennessee study, we recently sought to determine the degree to which Arkansas hospitals promote the use of child restraint devices, as evidenced through existence of discharge policies, educational programs, and car seat "loaner" programs.

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**Table 1.**  
**Arkansas Traffic Deaths, Injuries & Observed Car Restraint Usage Rates. Occupants aged 0-4, 1984-91.**

<u>Year</u>	<u>Deaths</u>	<u>Injuries*</u>	<u>Usage Rate</u>
1984	NA	901	NA
1985	10	925	NA
1986	7	880	20%
1987	14	975	NA
1988	9	1061	28%
1989	12	1064	NA
1990	13	1202	28%
1991	NA	NA	54%

\* = totals of Injuries in which use of restraints is known

NA = Not available

Sources: ADH Center for Health Statistics; Arkansas State Highway & Transportation Department.

## Methods

A survey form was sent in August, 1991, to all 83 hospitals licensed by the Division of Health Facilities to provide general inpatient medical services. All hospitals not responding by December, 1991, were telephoned in order to ensure 100% participation in the survey. Hospitals were asked whether they provided newborn services, "pediatric" services (for children older than neonates), or both. The 75 hospitals reporting provision of one or both of these services were then further asked:

1. Does your hospital have a written policy requiring that newborns and/or older infants and children leave the hospital in an approved child safety seat? If so, to what extent is the policy enforced if the parents cannot produce a safety seat at the time of discharge?
2. Does your hospital or hospital auxiliary sponsor any type of car seat loaner, rental, purchase or giveaway program?
3. Does your hospital provide any type of educational program to encourage the use of safety seats?

Based upon licensing records, hospitals were classified as proprietary, public, or nonprofit/church, as well as large (>300 beds), medium (100-300 beds), or small (<100 beds).

## Results

Ninety-six percent of the 75 hospitals reported that they provided pediatric services, while 81% provided newborn services. Other characteristics of the study hospitals are summarized in Table 2.

Overall, 24 (32%) of the facilities reported having policies requiring discharge of children in safety seats (Table 3). Twenty-three (38%) of the hospitals offering newborn services had policies for discharged neonates, while only nine (13%) of the hospitals with pediatric services reported having policies regarding discharge of older infants and children. Together, large and medium hospitals were more likely to have policies than small hospitals (50% vs. 17%, respectively). Public hospitals were less likely to have policies than either non-profit or proprietary hospitals.

Regarding enforcement of policies, a striking 96% of the hospitals having such requirements reported that these were strictly enforced, i.e. infants and children were not allowed to leave unless restrained appropriately. To achieve compliance, 21 of these hospitals provided a seat for parents unable to produce one themselves, whereas two referred the parents to loaner programs or made them purchase one prior to discharge. The one hospital that did waive the policy nevertheless reported that they referred parents to a loaner program at the time of discharge.

A total of 28 (37%) of the hospitals reported having some type of safety seat program currently in operation,

**Table 2.**  
**Characteristics of the Study Hospitals.**

<u>Size</u>	<u>No.</u>	<u>%</u>
Small (<100 beds)	41	55
Medium (100-300 beds)	25	33
Large (>300 beds)	9	12
<b>Type</b>	25	33
	28	37
Public	22	29
Nonprofit/Church		
Proprietary		
<b>Services Provided</b>		
Newborn (<1 month)	61	81
Pediatric (1 month-5 years)	72	96

whether sponsored by the hospital itself, hospital auxiliary, or other civic group. Rental programs (fee not refunded or only partially refunded when seat returned) predominated in terms of primary mode of operation (50%). These were followed by loaner (no fee or fully refunded fee) programs and purchase programs (21% each), and giveaway programs (4%). One program (4%) failed to specify type. Large hospitals tended to be more likely to have programs (67%) than medium (48%)



or small (24%) hospitals. Proprietary and nonprofit hospitals were each more likely to have safety seat programs than public hospitals (50%, 43% vs. 20%, respectively). Finally, hospitals who had a policy regarding child restraints at discharge (54%) were more likely to have programs than those who had no such policy (29%).

Overall, 57% of the survey hospitals reported routine provision of some sort of education intended to promote usage of restraint devices. This was most commonly delivered by way of instructional videotapes and/or individual counseling. There was a greater tendency for large hospitals to have educational programs (88%) than medium (72%) or small (41%) hospitals. Not surprisingly, hospitals with newborn services were much more likely to have educational programs than those not providing neonatal services (69% vs. 7%). Additionally, hospitals having a policy relating to safety seats were more likely to have education programs than those without (88% vs. 43%). No differences among proprietary, nonprofit, and public hospitals regarding the existence of education programs were noted.

## Discussion

Child restraint devices are now well recognized as an effective means of reducing automobile occupant deaths and injuries among young children. Usage rates of safety seats nationwide have progressively increased during the past decade, thanks largely to the efforts of the American Academy of Pediatrics, the National Highway Traffic Safety Administration, and numerous other safety and advocacy groups. Between 1982 and 1990, it is estimated that use of child restraints was responsible for saving the lives of 1546 U.S. children.<sup>4</sup>

As shown in Table 1, injuries among young motor vehicle occupants in Arkansas actually increased during the past decade, which may represent improved reporting and/or increased miles of "exposure" of infants and toddlers. Failure of Arkansas injury statistics to improve also undoubtedly reflects the state's relatively low car seat usage rate, which just improved to over 50% in late 1991. As with adult seat belt usage, available evidence supports the concept that children who are consistently unrestrained are actually at higher risk for involvement in potentially serious motor vehicle crashes than the general population.<sup>4</sup> Thus, injuries and deaths will probably not be significantly reduced until this high-risk minority of individuals is effectively reached, and usage rates thereby approach 100%.

It is commonly assumed that parents neglect to use car seats either because they lack knowledge or understanding of their benefits, or because they lack access to affordable restraint devices. In some families, particularly those of low socioeconomic status, car seats (and

**Table 3.**  
**Hospitals and Policies requiring**  
**discharge in child restraints.**

Size	No.	%
Small	7	17
Medium	13	52
Large	4	44
Type		
Public	4	16
Nonprofit/Church	12	43
Proprietary	8	36
Services Provided		
Newborn	23	38
Pediatric	9	13
Enforcement		
Strictly enforced	23	96
Waived/Referred	1	4

other preventive measures as well) may also be looked upon as a low priority when stacked against the exigencies of day-to-day survival. Finding ways to successfully motivate such individuals to engage in safer practices has proven, at minimum, to be quite challenging.

One strategy employed to promote safety seat usage, legislation, has proven only moderately effective to date but nonetheless represents a critical first step in the process. In fact, the observed improvement in child restraint usage in 1991 is almost certainly related to enactment of the more comprehensive state seat belt law that year. Unfortunately, enforcement of the child restraint statute remains sporadic, necessitating continued efforts by those outside the criminal justice system to encourage parental compliance. One such activity is patient education on the need for car restraints, which has now become an established part of anticipatory guidance provided by primary care physicians at well child visits. In addition, low-cost car seat loaner and rental programs have been touted as a means of improving low-income families' access to the devices, the retail costs of which may range from \$60-\$200. The Department of Health currently operates safety seat rental programs in 61 health units within the state, with convertible-type seats available for \$12 per year.

Hospitals that serve young children, and particularly those that have obstetrical services, would seem to be in an excellent position to provide education to expectant and new parents on the benefits of safety seats and the hazards of non-use. As seen from the survey, it appears that many hospitals in Arkansas are already



taking an active role in such counseling, though it is likely that the nature and extent of the information provided varies widely. Hospitals are also involved, albeit to a lesser degree, in actual provision of restraint devices to those in need. Such efforts are to be commended and encouraged, since they have been associated with at least a short-term significant improvement in correct usage of car restraints by parents.<sup>5,6</sup>

Hospitals should also consider instituting policies that require infants and young children to be restrained in appropriate devices upon discharge from the facility. While the percentage of hospitals in Arkansas having such policies was only slightly greater than that reported in the Tennessee study, the nearly uniform enforcement of policies claimed here suggests that once established, they are taken very seriously by hospital personnel in this state. Employed on a broader scale, this type of privately initiated and enforced "legislation" would undoubtedly go a long way toward protecting the very young from the most imminent threat to their health.

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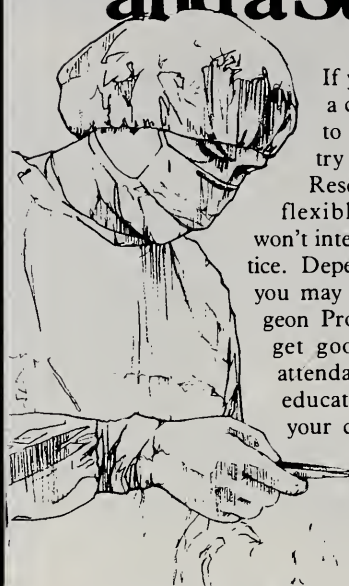
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# Phenomenological Approach to the Correct Diagnosis of Parkinson's Disease

W. Steven Metzger, M.D.\*

*When dealing with movement disorders, it is helpful to first decide what phenomenon one is observing. Tremors can be differentiated from most other movement disorders and are further classified according to their frequency, and whether they are present at rest or with action. The parkinsonian syndrome can thus be identified correctly in most cases, and the etiology can usually be determined clinically. Correct diagnosis is the first step in correct treatment.*

**T**he field of movement disorders currently plays an increasingly prominent role in neurology. This can be attributed to increasing understanding of basal ganglia and cerebellar function and the pathophysiology of movement disorders. In addition, many movement disorders can now be treated, an increasing number of clinical investigations are being carried out, and additional therapies are expected in the near future.

## Phenomenological Diagnosis of Movement Disorders

When dealing with involuntary hyperkinetic movement disorders (dyskinesias), it is helpful to first decide what phenomenon one is observing (Table 1). Akathisia consists simply of a restlessness and inner drive to move

about. Tremor is characterized by involuntary, rhythmic, oscillatory movements. Tremors are described according to their frequency, and whether they are predominant at rest, with postural maintenance or with intentional movement. (The syndrome of tremorless Parkinsonism is often included in the rubric of Parkinsonism.) Chorea consists of brisk, somewhat graceful, involuntary movements which resemble fragments of purposeful actions. Athetosis consists of slow, writhing involuntary movements involving the extremities and axial musculature. Chorea and athetosis are often coexistent. Dystonia is characterized by involuntary, sustained contraction of both agonist and antagonist muscles, often resulting in painful torsion spasms. Dystonias may be localized, segmental or generalized. Myoclonus consists of quick, involuntary muscle jerks, irregular or rhythmic, arising in the central nervous system. Myoclonus is less graceful and organized than chorea; it is not as prolonged as dystonic spasms. Tics resemble myoclonus but tend to be more repetitive and can temporarily be controlled by an effort of will. Ballismus is a violent, flinging movement similar to the motion involved in hurling a discus.<sup>1</sup> Most movement disorders can be categorized phenomenologically using this classification.

## Phenomenological Differential Diagnosis of Tremors

Tremors are further classified according to their frequency, and whether they are present at rest or with action. Action tremors are subclassified as being predominantly postural, or exacerbated by intentional movement (Table 2).<sup>2</sup>

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**Table 1.**  
**Phenomenological classification**  
**of movement disorders.**

Akathisia  
Tremor  
Chorea  
Athetosis  
Dystonia  
Myoclonus  
Tics  
Ballismus

### Differential Diagnosis of Parkinsonism

Parkinsonism is a syndrome characterized by a resting alternating tremor, muscular cogwheel rigidity, bradykinesia and diminished postural reflexes.<sup>3</sup> A typical parkinsonian tremor is of 3-7 Hz frequency, alternating supination and pronation, maximal at rest and decreases in amplitude with volitional movement. The upper extremities are most commonly affected, usually asymmetrically, with head tremor being less common.<sup>2</sup> Pragmatically, the syndrome of parkinsonism is the only cause of tremor present at absolute rest.

Parkinsonian tremors must be differentiated from action tremors, especially the postural tremor of essential tremor. Many essential tremor patients are anxious and never truly at rest when examined, appearing to have a resting tremor. Essential tremor is more common than idiopathic parkinsonism and can be as debilitating. About 30% of essential tremor patients are initially misdiagnosed as having Parkinson's disease.<sup>4</sup>

"Paralysis agitans" (Parkinson's disease; idiopathic parkinsonism) was first described by James Parkinson in 1817. This parkinsonian syndrome results from idiopathic degeneration of presynaptic dopaminergic neurons in the substantia nigra which project to the striatum.<sup>3</sup> Charcot disliked the term "paralysis agitans" and was the originator of the term "Parkinson's disease." Approximately 15% to 20% of Parkinson's disease patients are initially misdiagnosed.<sup>4</sup>

Parkinsonism can result from blockade of striatal postsynaptic dopamine receptors (drug-induced parkinsonism) by neuroleptics and metoclopramide (Reglan), or depletion of dopamine by reserpine and tetrabenazine. At least 15% of patients treated with neuroleptics (antipsychotic drugs; dopaminergic blocking drugs) develop parkinsonism. It is poorly understood why some patients develop drug-induced parkinsonism while others do not.<sup>5</sup> Drug-induced parkinsonism may persist for weeks to months following discontinuation of neuroleptic. Some patients with

irreversible drug-induced parkinsonism may actually be afflicted with idiopathic parkinsonism "unmasked" by the neuroleptic.<sup>6</sup> Myrianthopoulos found a significantly higher prevalence of idiopathic parkinsonism among relatives of patients with neuroleptic-induced parkinsonism than in the general population.<sup>5</sup> This suggests a possible genetic predisposition to develop drug-induced parkinsonism.

Parkinsonism was also a unique sequela to encephalitis lethargica that occurred pandemically between 1919 and 1926 due to infection with von Economo's agent (postencephalic parkinsonism).<sup>3,7</sup> These cases are becoming increasingly uncommon. It is controversial whether other viral encephalitides can produce residual parkinsonism in survivors.

Arteriosclerotic pseudoparkinsonism was originally described by McDonald Critchley in *Brain* in 1929, who originally believed that cerebrovascular disease could result in a syndrome identical to idiopathic parkinsonism. Critchley has been recently moved to observe that the rigid, paratonic syndrome accompanying multiple subcortical lacunes is truly a pseudoparkinsonian syndrome.<sup>8</sup>

**Table 2.**  
**Phenomenological Differential**  
**Diagnosis of Tremors.**

- Resting
- Action
  - I. Postural
    - A. Essential tremor
      - 1. Familial
      - 2. Nonfamilial
    - B. Accentuated physiological tremor
      - 1. Anxiety; fatigue
      - 2. Thyrotoxicosis
      - 3. EtOH withdrawal
      - 4. Sympathomimetics
      - 5. Lithium
      - 6. Tricyclics
  - II. Intention
    - A. EtOH intoxication
    - B. Phenytoin toxicity
    - C. Multiple sclerosis
    - D. Vascular
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    - F. Wilson's disease



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### WARNINGS

**Angioedema:** Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

**Hypotension:** Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

**Neutropenia/Agranulocytosis:** Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

**Fetal/Neonatal morbidity and mortality:** ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

### PRECAUTIONS

#### General

**Impaired renal function:** As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

**Evaluation of hypertensive patients should always include assessment of renal function** (see DOSAGE AND ADMINISTRATION).

**Hyperkalemia and potassium-sparing diuretics:** In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

**Surgery/anesthesia:** In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

#### Information for Patients

**Angioedema:** Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

**Symptomatic hypotension:** Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

**Hyperkalemia:** Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

## Accupril® (Quinapril Hydrochloride Tablets)

**Neutropenia:** Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

**NOTE:** As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

### Drug Interactions

**Concomitant diuretic therapy:** As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

**Agents increasing serum potassium:** Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

**Tetracycline and other drugs that interact with magnesium:** Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

**Lithium:** Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

**Other agents:** Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril administration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

### Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m<sup>2</sup> basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m<sup>2</sup>, respectively).

#### Pregnancy

**Pregnancy Category D:** See WARNINGS, Fetal/Neonatal morbidity and mortality.

#### Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

#### Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself.

In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

#### Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

### ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

**General:** back pain, malaise

**Cardiovascular:** palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

**Gastrointestinal:** dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

**Nervous/Psychiatric:** somnolence, vertigo, syncope, nervousness, depression

**Integumentary:** increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

**Urogenital:** acute renal failure

**Dther:** amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

**Angioedema:** angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

#### Clinical Laboratory Test Findings

**Hematology:** (See WARNINGS)

**Hyperkalemia:** (See PRECAUTIONS)

**Creatinine and blood urea nitrogen:** Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

\* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



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**Table 3.**  
**Differential Diagnosis of Parkinsonism,**

Action tremors (essential tremor, etc.)  
 Idiopathic parkinsonism  
 Drug-induced parkinsonism  
 Post-encephalitic parkinsonism  
 Arteriosclerotic pseudoparkinsonism  
 Hydrocephalus  
 Toxins (CO; Mn; MPTP)  
 Basal ganglia calcification (Fahr's disease)  
 Tumor  
 Infection  
 Multi-system atrophy (Shy-Drager syndrome)  
 Striatonigral degeneration  
 Progressive supranuclear palsy  
 Olivopontocerebellar degeneration  
 Hepatolenticular degeneration (Wilson's disease)  
 Cortico-basal ganglionic degeneration

Hydrocephalus can produce parkinsonism, most commonly without a tremor.

The parkinsonian syndrome is also known to result from exposure to certain environmental toxins, including manganese and carbon monoxide.<sup>3,7</sup> There has been tremendous interest recently in parkinsonism caused by the neurotoxic designer drug, MPTP.<sup>9</sup>

Basal ganglia calcifications are most commonly idiopathic and asymptomatic. They can be seen symptomatically associated with hypoparathyroidism. Fahr's disease is a rare, familial disorder with parkinsonism associated with basal ganglia calcifications; serum calcium and phosphorus are normal.<sup>3,7</sup>

Striatal neoplasms are very rare causes of parkinsonism.

In recent times, infections had become very rare causes of parkinsonism. When neurosyphilis was common, it frequently resulted in parkinsonism (mesencephalitis syphilitica). This entity has effectively disappeared, but parkinsonism has recently been noted to be associated with HIV encephalopathy.<sup>10</sup>

Progressive supranuclear palsy, striatonigral degeneration and olivopontocerebellar degeneration can be confused with parkinsonism. With atypical cases, Wilson's disease should always be considered. Cortico-basal ganglionic degeneration results in parkinsonism with dystonia, apraxia, and other cortical deficits.

#### **Treatment of Parkinsonism**

Treatment of idiopathic and other forms of parkinsonism is beyond the scope of this article. How-

ever, the first step in correct treatment is correct diagnosis. Utilizing a phenomenological diagnostic approach, in concert with knowledge of the disease entities described, most cases of idiopathic parkinsonism can be diagnosed correctly with history and examination. Supplemental diagnostic tests should be necessary in a minority of cases. When in doubt, expert consultation should be obtained.

#### **Acknowledgements**

The opinions and views expressed herein are those of the author and not of the Department of Veterans Affairs.

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# CHAR Proposal Makes State Less Fertile Ground to Recruit Young Smokers

*"The tobacco industry has the only product whose use ultimately results in death of the customer...We're not 'sin-taxing' but rather, we're taxing the end user of a product whose use results in premature death and disability and a cost to the public that (tobacco) users should bear the brunt of..."*

*If this tax is passed, it will have a positive effect on the health of Arkansans...a definite impact on the economy of state government. It's the sort of legislation being contemplated by other states."*

— *Dr. William N. Jones, Little Rock, as interviewed April 1, 1992 by Professor Jeanne Rollberg on KUAR-FM "Spotlight."*

**I** imagine the newspaper headlines if two fully-laden jumbo jets collided each day of 1992 and if no crash victim ever survived any of those tragedies. Wouldn't Americans demand drastic action?

Of course!

Yet we blithely condone a tragedy of equally epic proportion—one that kills 435,000 Americans a year. Among the victims are 4,200 Arkansans.

These victims, however, die not instantly in some fiery inferno. The fate of most is to endure a lingering slow-burn of a death—one brought on by diseases such as cancer or emphysema, brought on by their lifelong smoking habit.

Often, the abbreviated lifespan is attributable to a habit begun in the innocence of youth. Peer pressures and other environmental factors combine then with pro-smoking propaganda and ubiquitous tobacco ads to convince impressionable youths that success is some-

how inextricably linked with the simple act of lighting up.

Until now, efforts at convincing youth to the contrary have been underfinanced and largely ineffective, despite the best efforts of health professionals and nonprofit groups.

But now, the Arkansas Medical Society has joined with a determined coalition of influential Arkansans—business and medical professionals, advocates for youth and the elderly—to cry enough!

The coalition, known as CHAR (Coalition for a Healthier Arkansas), is a force to be reckoned with—one determined to see that those most deeply affected by the smoking menace (and those most susceptible to it) will either be helped to quit the habit or asked to pay for its long-term costs to society.

The efforts really began during the state General Assembly's 1991 session when an intrepid band of advocates for improved services to elderly Arkansans labored tirelessly against heavy odds and big tobacco megabucks to add a penny sales tax to the cost of each pack of cigarettes sold in Arkansas.

Polished, poised and professional lobbyists representing tobacco giants such as R.J. Reynolds-Nabisco and Phillip Morris tried to reach lawmakers and scuttle the effort.

But the senior citizens' determination carried the day. And the penny tax now nets seniors' transportation needs more than \$2 million a year.

Older Arkansans since have benefited from a more reliable source of funding for transportation services—mobility that made their senior centers and other destinations more accessible. That heightened accessibility, in turn, lets older Arkansans live more independently.



Tobacco interests who, in 1991, refused to concede even a penny of cigarette tax will hardly stand idly by now as CHAR's coalition of nonprofit groups and health professionals seeks to have Arkansas voters add a full 25-cent tax to the cost of a cigarette pack by 1993.

CHAR announced that objective March 27 when representatives from such nonprofit groups as the American Cancer Society and Heart and Lung Associations joined professional health services providers and advocates for older Arkansans to announce their new coalition.

CHAR since has begun a petition drive seeking 60,000 or more signatures to submit the proposed surtax referendum on the November 3 general election ballot. A February poll showed that 65 of registered Arkansas voters, including many smokers, already favor the idea of an added 25-cent tax contained in what will be known formally as the **Cigarette and Tobacco Products Tax Act of 1992**.

Most of those surveyed said they favor such a surtax, so long as the estimated \$68 million in new annual revenues is specifically earmarked for certain worthwhile programs.

The initiated Act will apportion revenues thus:

- \$34 million (about half) to be matched with federal Medicaid funds to pay for medical services primarily to benefit the state's elderly and indigent patients. Many such older Arkansans have contracted illnesses after a lifelong smoking habit and now have no money to pay for the costly medical care now required.
- \$13.6 million to expand services benefitting older Arkansans—specifically such popular programs as "Meals on Wheels" for home-bound elderly people and transportation services for others.
- \$10.2 million to be spent through state Health and Education Departments for health education to teach Arkansans—young and old, smoker and non-smoker—about health hazards of drug and alcohol abuse, smoking and use of other tobacco products.
- \$3.4 million to fund an effective program encompassing not only research into smoking-related illnesses, but also disease surveillance programs and a statewide cancer registry program.
- \$6.8 million to let state agencies improve underfunded programs to aid families—especially neglect and child abuse victims.

The Act heavily emphasizes indigent medical care and health education out of the firm conviction that those who most heavily support the tobacco industry's

continued success in Arkansas also should bear the burden of paying for its aftermath.

And the costs, paid now by the public as a whole, are appalling.

Cigarette smoking—the nation's largest single preventable cause of death—claims more than 400,000 U.S. lives every year—about 4,200 in Arkansas where 30% of men and 22% of women still smoke.

About 16% of Arkansas deaths are directly attributable to smoking and such resultant diseases as lung cancer and emphysema. About 22% of male deaths are smoking-related.

Smokers who survive cost society, too, through increased medical and care costs associated with morbidity. About \$135 million a year is spent on smokers in Arkansas hospitals, nursing homes and other long-term medical care facilities managed by health services providers.

Among indirect costs of smoking is \$363 million a year in lost work productivity and related costs. Taken together, the Arkansas economy loses more than a half billion dollars a year—\$209 a person—from costs attributable to tobacco use.

That is not an acceptable loss in a modern, enlightened society. And what makes such a loss still less acceptable is the disastrous effect smoking and tobacco use has on the state's young people. They are among those demographic groups systematically and specifically targeted by East Coast tobacco giants as future tobacco products customers.

Not by accident did thousands of young Arkansans troop through Little Rock's Ricks Armory in 1991 to see a Phillip Morris-sponsored Bill of Rights display. Nor is it coincidence that the comical cartoon caricature of suave, debonair "Joe Camel" now is visible statewide and on mobile, outdoor ads that travel our highways.

Joe Camel's appeal for youth is obvious.

Tobacco companies well know that 60% of smokers begin smoking by age 14. Fully 90% start smoking by age 19.

A struggling, obsolescent tobacco industry—seeing its best customers die or give up smoking—needs such a fertile recruiting ground among young Arkansans, professional women, racial and ethnic minorities... among any group readily targeted by clever cigarette advertising.

That's why CHAR and its supporters propose renewed efforts to reach such tobacco target markets with cogent health education and counter-advertising. Contrary to the messages of the industry's gnarly, macho Marlboro man and slinky Eve and Virginia Slims, Arkansas youth must learn that smoking is less synonymous with success than with slow death.

Kaye Hadley of the American Heart Association in Arkansas noted recently that a smoker's risk of heart attack is more than double that of a non-smoker's.



And smokers need to know—as Ray Scott, executive director of the Arkansas Association of Area Agencies on Aging, said March 27, 1992—that smoking greatly increases their health-care costs later in life.

And they need to recognize smoking—as Dr. William N. Jones, a physician chairing CHAR's Steering Committee, said—as Public Enemy No. 1.

Smoking, Dr. Jones said, kills more Americans each year than the combined ravages of AIDS, cocaine and heroin, alcohol abuse, fires, auto accidents, homicide and suicides!

Dr. Jones, immediate past president of the Arkansas Medical Society, said a favorite tactic of big tobacco, in fighting such cigarette tax efforts, was to vilify physicians as profiting from medical fees charged ailing smokers.

But if the medical community truly sought to enrich itself, Dr. Jones said, it would fare far better to ally with tobacco interests. After all, he added, the industry seeks to increase the number of smokers who, sooner or later, require extensive—and expensive—medical services.

Instead, such groups as the Arkansas Medical Society and Arkansas Academy of Family Physicians count themselves as staunch supporters of CHAR's Initiated Act seeking to limit and tax more heavily Arkansas sales of cigarettes and tobacco products.

Despite what seems to be a prevalent antitax mood in Arkansas, Arkansans surveyed so far indicate that CHAR's proposal is a tax all of us - smokers and non-smokers alike - can live with.

Coalition members include not only the American Cancer Society, American Lung Association and American Heart Association, but also the AARP, Health Care Association, Arkansas Optometric Association, Association of Area Agencies on Aging, Arkansas Medical Society, Arkansas Hospital Association, Arkansas Pharmacists Association, Arkansas Optometrists Association, Arkansas Academy of Family Physicians, the March of Dimes, Association of Home Health Agencies, Society for Public Health Education, and the Mental Health Council of Arkansas.

Those CHAR members support an increase from the current 22-cent a pack state tax on cigarettes. By 1993, the Act will increase the tax to 47 cents a pack. Federal excise tax now is 16 cents on tobacco. An equivalent state tax will be assessed on sales of chewing tobacco, cigars, snuff and other tobacco products.

Dr. Jones called the tax proposal less an emotional appeal than "a public health and economics issue. Last year," he said in an interview broadcast on Little Rock's KUAR-FM, "tobacco companies lost more than 430,000 of their best customers to smoking-related diseases. So they now must recruit another 3,000 additional users daily just to maintain their profits from their products. They target youths as their main recruits. Some smoking has to do with effects of peer pressure and family experiences. But there's no question that advertising has a very adverse effect on youth taking up the habit."

"A higher price for cigarettes should deter smoking among younger smokers who have less disposable

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income. Every time the price on tobacco rises 10%, 12 to 14% fewer children will stop using tobacco, compared to 4% among adults. Children are cost sensitive."

"Tobacco industries see the handwriting on the wall, and they are diversifying as fast as possible. But you can't stop a business as large as tobacco instantaneously without having an impact throughout society. And for that reason, 20 years ago, the AMA adopted the policy to seek a smoke-free society by 2000. This allows adjustment in the way people earn their livings."

"It's the most preventable cause of death in this country. Education can only go so far. Behavior has to be modified and that's the individual's decision. The individual must make the right choice."

Part of the Act's revenue will help educate children regarding abuse of drugs, alcohol and the use of tobacco.

Dr. Jones said each CHAR member has his own reasons for supporting the surtax. His own motive, he said, was smoking's impact on children.

Since Californians began collecting a similar tax in 1989, 12% of children there and 4% of adults had ceased smoking. "A very positive effect," he called it, despite the tobacco industry's \$25 million effort trying to defeat the California proposal.

There's already Arkansas support for such a tax, too. A February statewide poll revealed 65% of respondents were willing to support 25-cent tax increase on cigarettes.

"Most smokers know they should not smoke," Dr. Jones said. "But tobacco is an addictive drug. There was a great number of smokers in the pool of people we polled."

Dr. Jones told a KUAR-FM interviewer CHAR's primary adversary would be the "inexhaustible resources" of major tobacco companies. "If you are in the business, it's important to maintain a profit. And tobacco companies make \$500 million in Arkansas each year."

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Another cogent reason for the surtax, Dr. Jones said, was repeal of the Medicaid Provider Tax approved during the 1991 legislative session. Basically, it had taxed all the medical services—hospitals and anything related to medical care—to create a \$30 million the state revenue pool, matched 3:1 at the federal level. That has brought in a total \$240 million to state Human Services Department for indigent health care.

But that tax was eliminated, effective June 1993, he said. And nothing has been announced at the state level to replace that revenue.

"Many client services come under Medicaid and if we lose \$240 million, there's a big shortfall no one in state government will want to handle."

That's one stimulus for this Act, but CHAR's ultimate goal is to have positive effect on public health and economics. If we don't approve this tax, there's no other plan to recoup these losses after June 1993. And without this plan, it's conceivable costs will be shifted to the general public.

"Personally," Dr. Jones added, "the tax revenue is the least important aspect of this effort. The tax's effect on the public health is my biggest concern." ■

### ORTHOPAEDIC RESEARCH AND EDUCATION FOUNDATION

The members of the Order of Merit set the example for their colleagues, orthopaedic industry and the public. They demonstrate the power of philanthropy in expanding knowledge in orthopaedics for the relief of human suffering. Following is the Arkansas Roster of the 1991 Members, including all orthopaedists from Pine Bluff which has, thereby, been designated a "City of Merit."

- Banks Blackwell, M.D., Medical Director -

James A. Arnold, M.D., Fayetteville  
Mr. Michael M. Bailey, Little Rock  
Banks Blackwell, M.D., Pine Bluff  
(A Memorial Tribute to Lyman Smith, M.D.)  
Charles A. Clark, M.D., Pine Bluff  
Robert R. Gullett, Jr., M.D., Pine Bluff  
(A Memorial Tribute to Richard LeBlanc, M.D.)  
Dr. & Mrs. Peter J. Irwin, Fort Smith  
Philip H. Johnson, M.D., Little Rock  
Dr. & Mrs. James M. Kolb, Jr., Russellville  
Dr. & Mrs. Charles A. Ledbetter, Harrison  
(A Tribute to Donald B. Kettelkamp, M.D.)  
John O. Lytle, M.D., Pine Bluff  
Dr. & Mrs. Bruce L. Smith, Jr., Hot Springs  
J. L. Vander Schilden, M.D., Little Rock  
(A Memorial Tribute to Richard Webber, Ph.D.)





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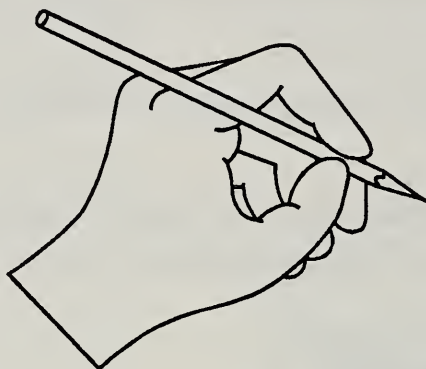


# Topics in Search of Authors

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# Walking for Fitness and Fun

Hampton Roy, M.D.\*

I started walking to work about 15 years ago and, except for a three year hiatus, have walked to work ever since. I live in the downtown area and walk seven miles to my office on Monday's, Wednesday's and Friday's. I normally leave the house about 5:00 a.m. and it takes me 1 1/2 to 1 3/4 hours. I walk the same route each time and do not carry any type of tapes or music but am left to my own thoughts during the walk. The walking that I do is fun for me but at the same time, I am "going to work," so it is a useful type of recreation. I was astounded several years ago when the book, *Walking Medicine*, had several pages about me and my lifestyle.<sup>1</sup> More recently, the *Reader's Digest* and *Prevention Magazine* had articles that also mentioned me as well.<sup>2,3</sup> The reason I have been mentioned in these three publications, I feel, is because so few people walk. We have sidewalks in many of our cities in Arkansas but if you go out at various times of the day, you rarely find people walking.

Walking is a healthy exercise. It requires a minimum of equipment and can be a lifelong, regular type of exercise that provides many health benefits. There are 10 health benefits that I am aware of that walking provides.

\* Dr. Roy is an ophthalmologist with the Arkansas Cataract Center, in Little Rock.

1. Cardiovascular Health. In the last 30 years, there have been 40 major studies that have documented that with physical activity there is a decreasing incidence of myocardial infarction and sudden death. This includes individuals such as London bus con-

ductors, postmen, physically active railroad workers and longshoremen doing heavy physical labor.<sup>4</sup> Three very recent studies link physical activity to improved cardiovascular health.<sup>5-7</sup>

2. Mental Benefits. There have been several reports indicating a reduction in anxiety and depression and an enhanced sense of well-being with regular exercise.<sup>8,9</sup> Recently, a study has demonstrated that 40 minutes of fitness walking significantly reduces anxiety and tension.<sup>10</sup> This is what I have found as a very definite benefit from walking.

3. Weight Loss. Walking may help with weight loss. In addition to the energy expended while walking,

physical activity also contributes to the weight loss program by decreasing the appetite. The metabolic rate is raised after exercise for one to four hours and it helps maintain lean body mass. Probably the most effective program for weight loss is a combination of diet and exercise. I have found that my weight is fairly stable and that I could stand to lose some weight but I have not cut back on my diet with my



Dr. Roy walking for fitness and fun.



walking program. Walking, however, is a low-impact activity with a low risk of injury thus, it is very appropriate for heavier people.

4. Cholesterol. With regular walking there is a decrease in total cholesterol level and increases in the high-density lipoprotein. A recent study found that long-term low level physical activity such as walking, was positively associated with HDL2 levels among postal carriers.
5. Hypertension. There is some suggestion, but not conclusive evidence, that walking does lower the blood pressure. Also, as many individuals are overweight that have hypertension, weight loss has been shown to lower blood pressure.
6. Aging. Aerobic capacity declines with age. Sedentary men had a threefold greater decline in maximum oxygen consumption than active men. In one study, individuals 70-86 years of age who participated in a 12 week walking program increased their  $VO_2$  maximum by 13%.
7. Osteoporosis. Osteoporosis is a common problem for older adults particularly women. Studies with humans have shown that weight bearing exercise such as walking will increase the bone mineral content or slow its rate of loss.
8. Cardiac Rehabilitation Walking. Almost every cardiac rehabilitation program uses supervised walking programs as the main form of exercise. Reductions in cardiovascular events has been shown when exercise has been combined with a well-structured program of risk factor reduction.
9. Walking During Pregnancy. A significant increase in aerobic capacity of mothers who exercise has been found in comparison in those who did not. Walking in the post-partum period can also help

restore muscle tone and body weight to levels occurring before pregnancy.

10. Diabetic Walking. Walking is recommended for diabetics in that it increases the sensitivity to insulin, helps in weight control and may reduce other risk factors for cardiovascular disease.

Physicians can have a strong impact on patient activities. Walking is an effective form of exercise to help patient's establish a consistent lifelong exercise program that can carry the most important long-term health benefits. I would suggest that you and your patients look to walking for fitness and fun.

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*For a complete list of references, please contact the AMS office.*

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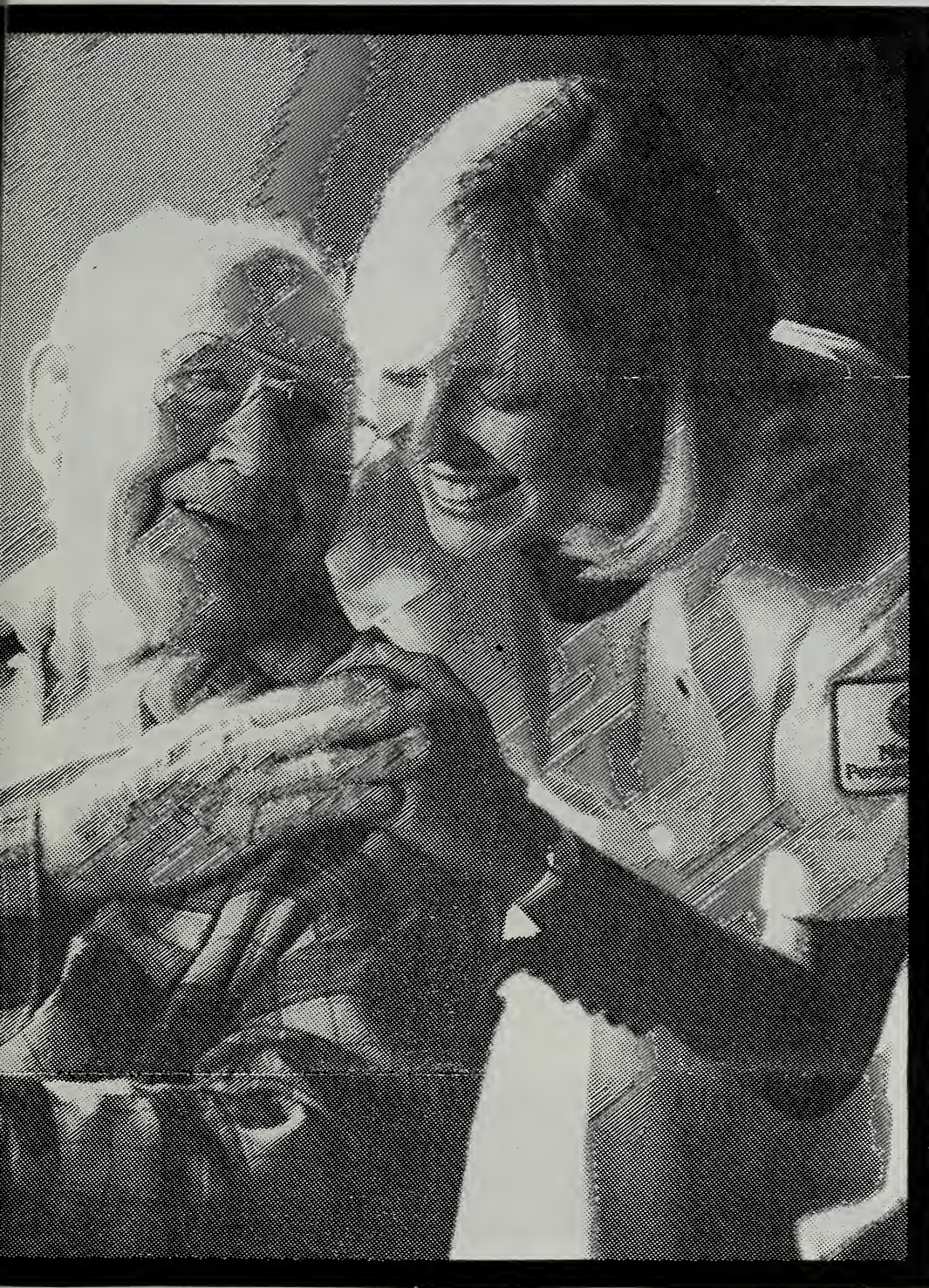
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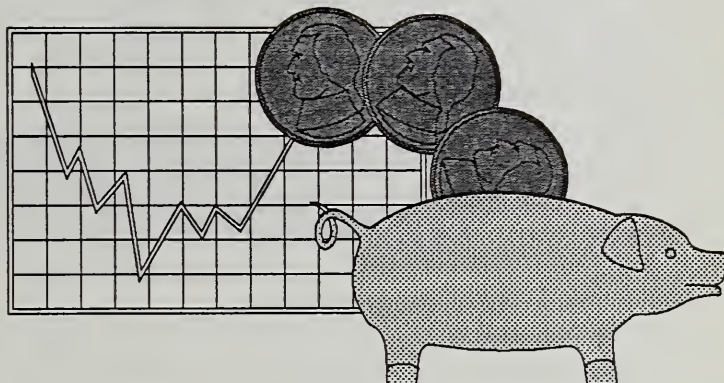
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# The Cost of Waiting

Graham Smith\*



**M**any individual investors who enjoyed the high interest rates of the 1980's are concerned about today's low interest rates, and yearn for the return of higher yields. For a variety of reasons - a slow economic recovery, the heightened "savings" mentality of the nation's population, and low inflation - many analysts believe that interest rates will not return to generous levels of the past decade, but rather will remain within a narrow trading range throughout the 1990's. Nevertheless, the current level of interest rates pose an unsettling dilemma for many investors. Should one take action now, and risk buying at lower yields than might be available later, or should the investors wait and invest a year from now, presumably at more "acceptable" levels.

The investment decision, whether to lock in current long-term rates or stay in money-market funds in anticipation of higher interest rates, seems to be based solely on the direction of higher interest rates. There are, however, some other important factors to consider over the near term. The question, then, is what is the consequence of waiting for a clearer direction of interest rates. Consider two scenarios:

Investor "A" usually makes his municipal purchases with a "buy-and-hold" strategy. He is concerned about making a wise decision, and maximizing cash flow. He be-

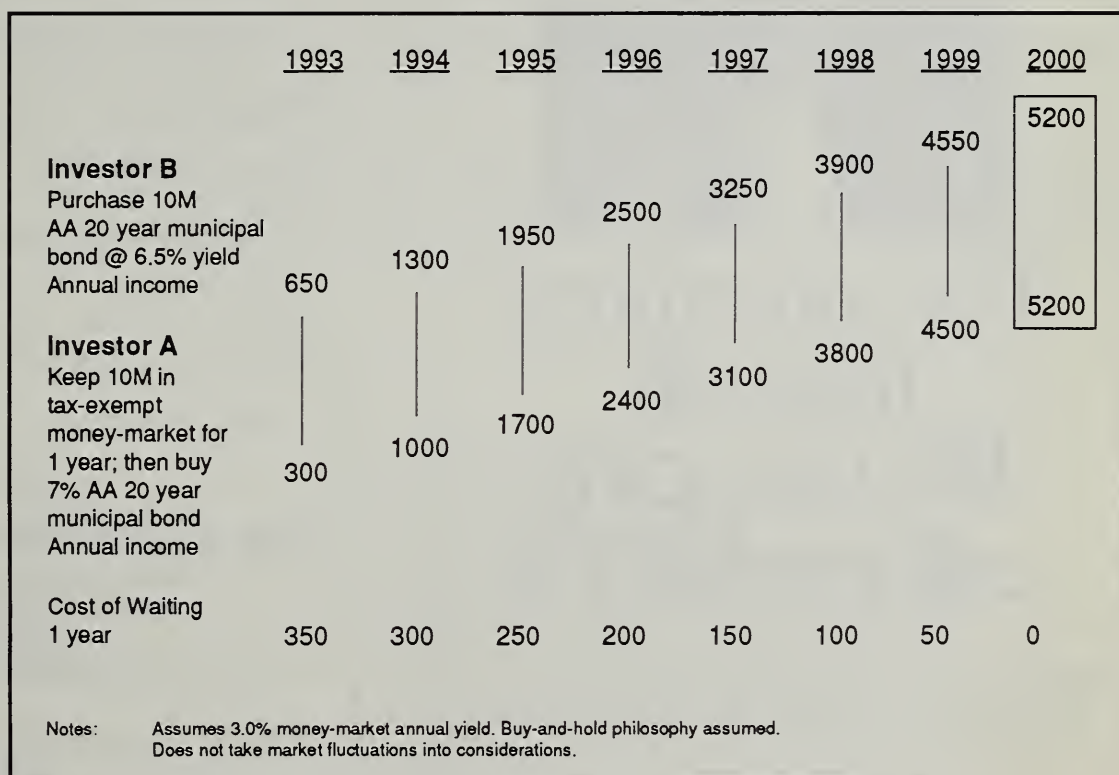
lieves that tax-free yields will reach 7% within one year; therefore, he keeps his \$10,000 in money markets, with a tax-free 3% yield, rather than buying today's 20-year AA municipal bond yielding 6.5%. If he's right, rates will go to 7% and he'll make the longer-term commitment at that time. Investor "A's" decision has the following cash-flow consequences:

Invest \$10,000 in tax-free money-market  
@ 3% - earns \$300

versus

Invest \$10,000 in 20-year AA municipal bond  
@ 6.5% - would earn \$650

Opportunity Cost - \$350





"Investor B" (same profile) decides not to wait for 7% yield. She invests \$10,000 today in the AA 20-year 6.5% municipal bond.

As you can see, it took "Investor A" seven years to break even with "Investor B" on a pure cash-flow basis. Even though "Investor A" was right, and interest rates rose to 7% by the end of one year, was the cost of waiting the best economic decision? It depends. Certainly money markets play a vital role of providing liquidity in an individual's portfolio. And of course, a bond yielding 7% over 20 years will also return more than a 6.5% investment. But over the near term - over the next seven years - that 6.5% security outpaces the higher-yielding instrument on a current cash flow basis.

And isn't money in your pocket today better than money later? Today's low interest rates on short-term investments, and the spread between short-term and longer-term yields, argue strongly for taking action now, as do the "real returns" (the difference between current returns and the rate of inflation) available in today's low-inflation environment. In our view, the cost of waiting is just too expensive. Even if you are right about future interest rates, you may very likely be wrong to wait for them. ■

\* Mr. Smith is a financial consultant with Merrill Lynch in Little Rock, Arkansas.



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# Differences Between Medical Decisions and Moral Judgments Can Injure Patients and—Sometimes Lead to Legal Hassles

Robert J. Miller\*

**S**hould alcoholics, drug addicts, homosexuals, the homeless, prostitutes, etc. be relegated to less vigorous and enthusiastic medical care because the practitioner disapproves of their lifestyles? Society's answer today is no.

Yet, since physicians have spent their lives adhering to self-imposed high standards, it is natural for them to use those same high standards when evaluating the behavior of troubled patients—particularly when the patient's lifestyle directly contributes to his or her physical ills.

Example: A man was brought, unconscious, to a hospital. He was unkempt and smelled of alcohol. This patient had been previously admitted to the hospital with alcohol-related problems. A physician ordered that the patient, who was homeless, be placed on a cot to "sleep it off." He never woke up. He died of a myocardial infarct.

Those who provide health care do not have the right to translate judgments about lifestyles, bad habits, or foibles of their patients into medical decisions. Such judgments can impede or destroy the doctor-patient relationship, can muddy diagnostic decisions and can result in less-than-satisfactory results for the patient.

Example: A young man violated the laws of the state in which he lived and drove his motorcycle without a helmet—into the side of a diesel truck. An article appearing in a medical journal commented on the reconstructive surgeries and on the patient's residual scarring. The article opined that the patient's career as a truck driver did not require the same level of beauty that might be necessary "if he were a professional." There was a judgment in the writer's definition of the word "professional."

When treatment modalities are scarce, non-medical ethical considerations can subvert medical judgments. In the early days of kidney dialysis, for example, life-and-death decisions were made based on the patient's standing within and value to the community. Problems arising from issues other than medical care, may be within the purview of the ethicist, rather than the physician.

Example: A middle-aged woman was treated in an emergency room for an automobile-related injury. Although she was not completely lucid, the patient repeatedly requested that a specialist be called to look at her hand. It was not until the woman's family members arrived that the ER staff discovered that the woman was a concert pianist. Upon finding that a hand specialist had not been summoned, the family demanded to know why. "Well, gee!" exclaimed the disconcerted ER physician, "I thought she was just a housewife." The plaintiff's attorney made certain that there were several housewives on the jury.

---

\* Mr. Miller is vice president of Consumer Affairs and Risk Management for The Medical Protective Company of Fort Wayne, Indiana.



Words that can be construed to have negative meanings (such as loser, trouble-maker, obnoxious, hysterical, or crazy) have fuses attached to them. Such words can color and affect conscious (or unconscious) decisions made about the patient's care. If the patient is alcohol-dependant, the chart should reflect the condition. Let the medical facts speak for themselves. Moralistic evaluations should be channeled into some other, non-medical forum.

Example: A nurse, passing a doctor in the hallway of his office, loudly whispered, "....an STD in Room 4." Unfortunately for the nurse, the patient heard the whisper, was well-award that STD stands for sexually transmitted disease, and was angry enough to consult with an attorney over the incident.

Time and again, physicians must stand by and helplessly watch as a patient self-destructs: the anorexic who will not be cured, the drug user who refuses to acknowledge her problem, the hypertensive eating his way to the undertaker. But, if a doctor-patient relationship exists, then it is the doctor's responsibility to continue to intervene with the patient for his or her own good, and the records should show consistent attempts by the doctor to suggest and support recovery.

Federal regulations will increasingly be called into play when medical professionals wish to avoid dealing with troubled patients.

Example: We have read of a recent case that involved the issue of "dumping," as well as unacceptable judgments about a patient. A nurse told everyone involved in a patient's obstetric care that the patient was uninsured, that she should be kept under observation for a few hours only and that she should then be discharged. The nurse also wrote in the patient's chart that there was no insurance coverage. The patient's baby was later declared dead in utero. The patient sued, claiming that, because she had no insurance (and everyone knew it), she was given only token care, and that appropriate measures would have saved her baby. The patient's anger and humiliation concerning these insurance remarks may well have contributed to her decision to sue.

There is an old saying that bounces around within education circles. Teachers, frustrated by the challenges presented by difficult children, pronounce it to each other. "It is the most unlovable child who needs the most love." Even those who want to scream when they hear it, admit its truth. Perhaps this old saw may also have an application for medical professionals—who must also want to scream when they see a patient intent on short- or long-term self-destruction. Is it not the patient most intent on being ill who needs the most intent care? ■



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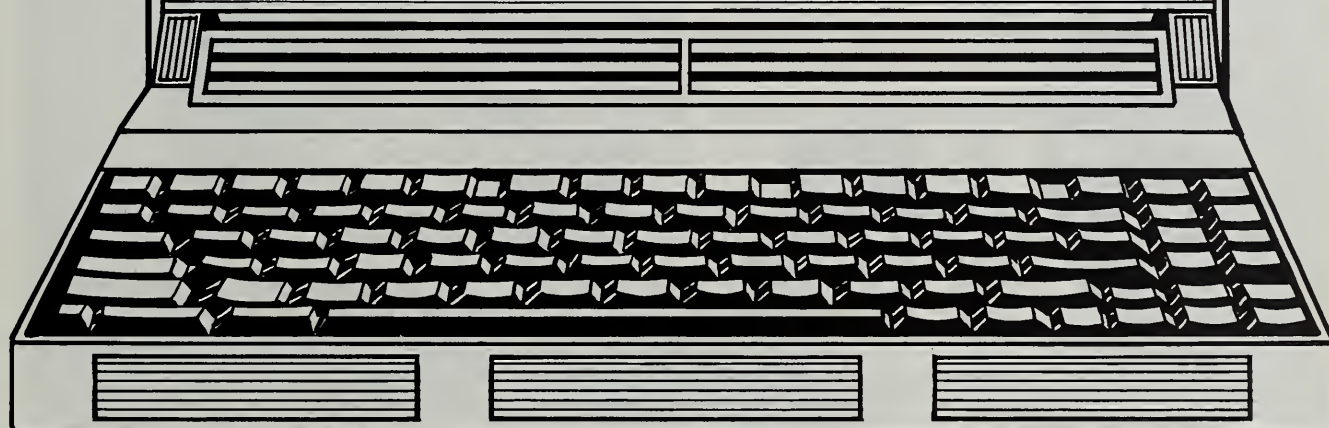
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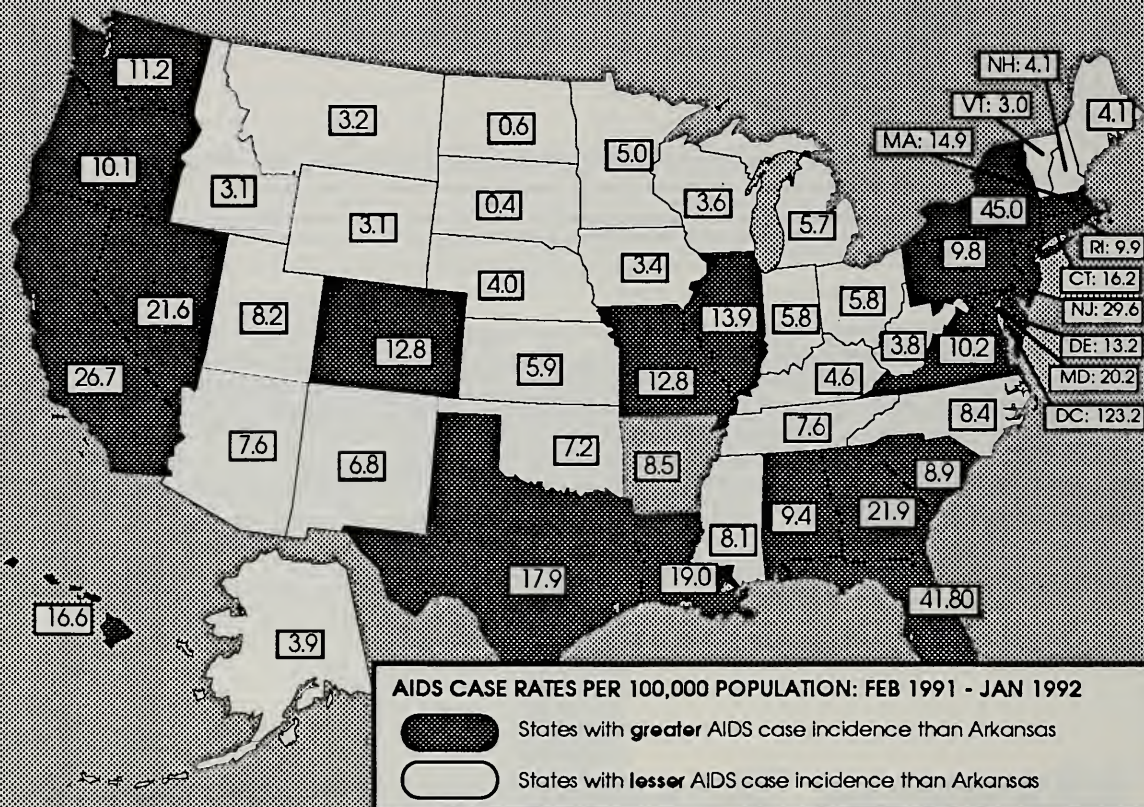
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# Arkansas HIV/AIDS Report

## 1983-1992

Arkansas Cases		United States Cases	
Reported: FEB '91 - JAN '92	200	Reported: FEB '91 - JAN '92	45,758
Rates per 100,000 population: FEB '91 - JAN '92	8.5	Rates per 100,000 population: FEB '91 - JAN '92	17.9
Cumulative Reports: 1983 - MAR '92	690	Cumulative Reports: 1980 - JAN '92	209,693
Adult	673	Adult	206,171
Pediatric	17	Pediatric	3,522
Deaths: 1983 - MAR '92	386	Deaths: 1980 - JAN '92	135,434
Adult	380	Adult	133,554
Pediatric	6	Pediatric	1,880
Mortality Rate	55.9 %	Mortality Rate	64.6 %



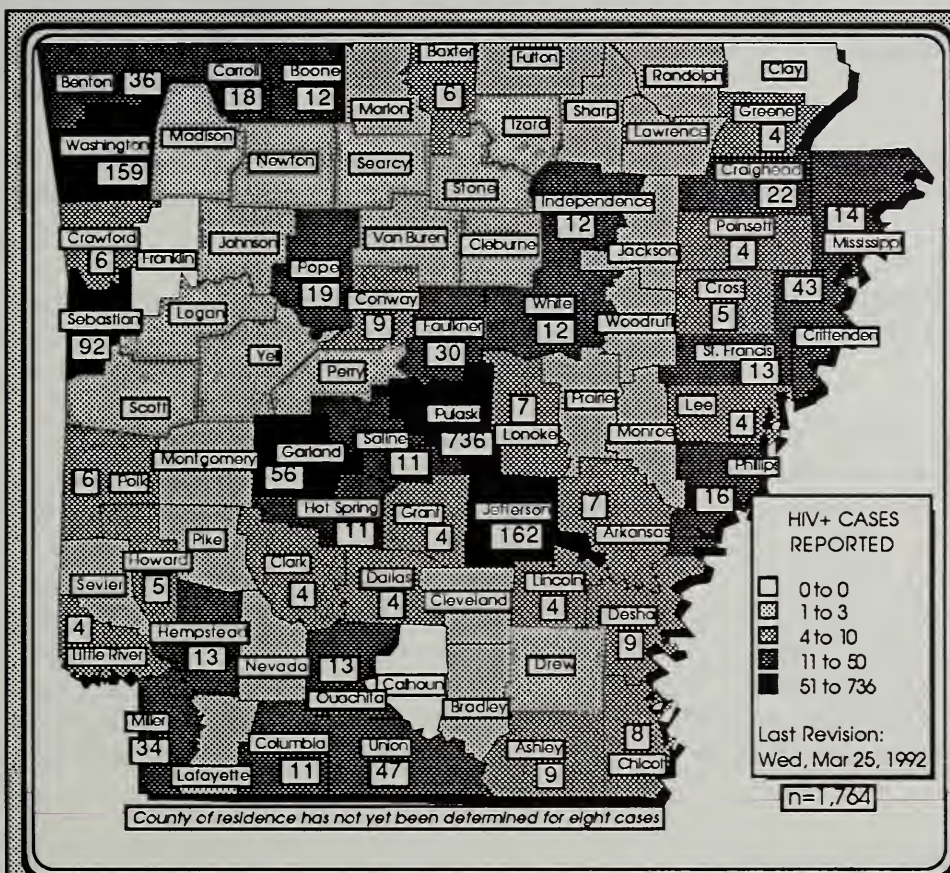
Arkansas Cases by Risk Group		United States Cases by Risk Group	
Men who have sex with men	62.8 %	Men who have sex with men	57.3 %
Heterosexuals who use IV Drugs	11.0 %	Heterosexuals who use IV Drugs	22.2 %
Men who have sex with men and use IV Drugs	9.1 %	Men who have sex with men and use IV Drugs	6.4 %
Heterosexual contact with person at risk	5.4 %	Heterosexual contact with person at risk	5.8 %
Transfusion with blood products	4.5 %	Transfusion with blood products	2.2 %
Infants born to HIV-infected mothers	2.0 %	Infants born to HIV-infected mothers	1.4 %
Persons with hemophilia	1.7 %	Persons with hemophilia	0.9 %
Risk unknown at this time	3.5 %	Risk unknown at this time	3.8 %

Source: AIDS Surveillance Unit, Arkansas Department of Health.



# Arkansas AIDS Report

## 1983-1992



### Reporting Requirements

HIV and AIDS case reporting by name and address is required by Arkansas Statute: Act 967 of 1991.

Reporting is required at the time an individual tests positive for HIV and again when the individual becomes symptomatic with AIDS.

Timely and accurate reporting is necessary to insure effective response to the epidemic.

### Who is Required to Report HIV/AIDS

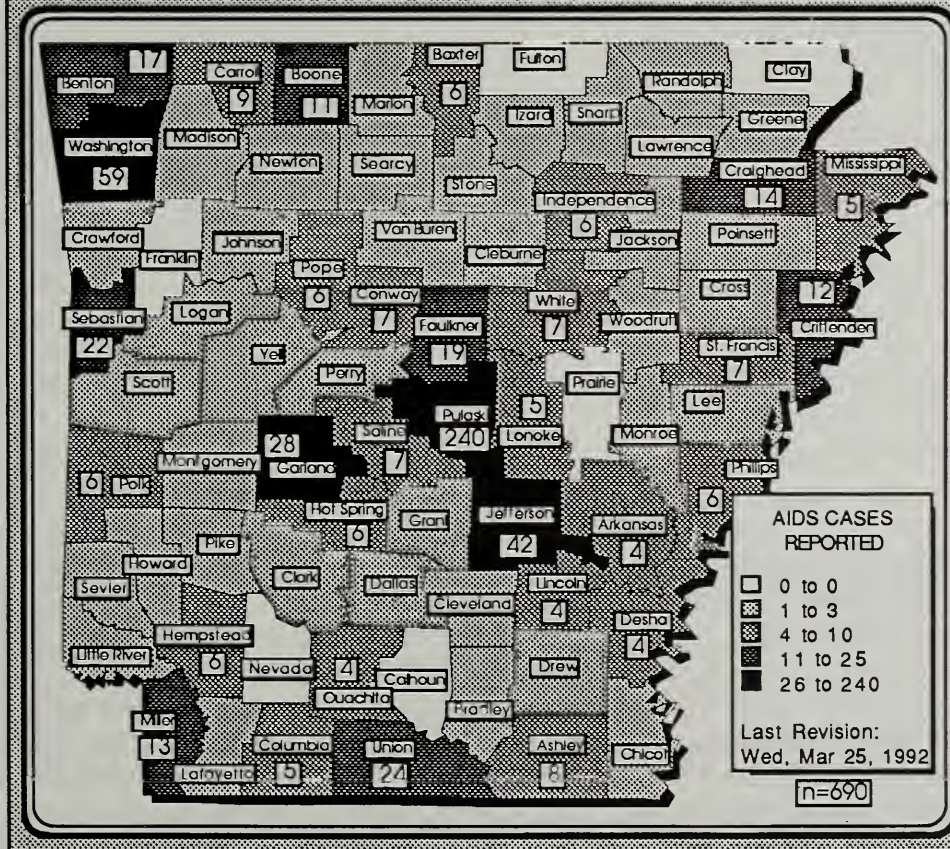
- Physicians
- Nurses
- Infection Control Practitioners/Chairpersons of Infection Control Committees
- Laboratory Directors
- Medical Directors of: Nursing Homes Home Health Agencies
- Clinic Administrators
- Program Directors of State Agencies

### How to Report HIV/AIDS

(1) Reporting sources should complete an HIV/AIDS case report form when they are knowledgeable that a patient has tested positive for HIV.

(2) When that patient becomes symptomatic, the Surveillance Unit should be updated by form or by phone.

Questions regarding case reporting may be directed to Jan Bunch, HIV/AIDS Surveillance Coordinator, 1-501-661-2387.





# AMS Newsmakers

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**Dr. C. Murl Baker**, an otolaryngologist from Springdale, has been elected chief of staff at Springdale Memorial Hospital.

**Dr. L.J. Pat Bell II**, an family physician from Helena, has been elected vice chief of staff of Helena Regional Medical Center.

**Dr. John Deaton**, a cardiologist from Fort Smith, has been elected secretary of staff of Sparks Regional Medical Center.

**Dr. W. John Giller**, a El Dorado orthopaedic surgeon, has been appointed associate councilor for Arkansas by the Southern Medical Association.

**Dr. Joe L. Hargrove**, a Little Rock cardiologist, has been named to the board of trustees at the University of Arkansas. Dr. Hargrove is associated with the Cardiology and Medicine Clinic in Little Rock and is an assistant professor of medicine and cardiology at the University of Arkansas for Medical Sciences.

**Dr. Charles Ledbetter**, a Harrison orthopaedic surgeon, was reinducted into the American Academy of Orthopaedic Surgeons where he will serve his second term as the Arkansas councilor.

**Dr. M.A. McDaniel**, a general practitioner from Helena, has been elected secretary/treasurer of Helena Regional Medical Center.

**Dr. Terence McGuire**, of Little Rock, has been named medical director of Inpatient Services at Living Hope Institute, a psychiatric and substance abuse facility at Doctors Hospital. Dr. McGuire is a behavioral scientist with over 30 years service to the National Aeronautics and Space Administration (NASA).

**Dr. Robert Miller**, a gerontologist from Helena, has been elected chief of staff of Helena Regional Medical Center. Dr. Miller is also a member of the Arkansas State Medical Board.

**Dr. Andre Nolewajka**, a Fort Smith cardiologist, has been elected to fellowship in the American College of Physicians for scholarly and professional achievements.

**Dr. Marcus D. O'Brien**, a pediatrician from Batesville, was elected to fellowship in the American Academy of Pediatrics.

**Dr. Terryl J. Ortego**, a gastroenterologist from Springdale, has been elected medical staff secretary at Springdale Memorial Hospital.

**Dr. Henry Rogers**, a retired pediatrician from El Dorado, was named to the board of directors of Arkansas Children's Hospital Research Center.

**Dr. Kenneth Rosenzweig**, a Fort Smith orthopaedic surgeon, has been inducted as a fellow of the American Academy of Orthopaedic Surgeons.

**Dr. John B. Weiss**, a cardiovascular surgeon from Springdale, has been elected vice chief of staff at Springdale Memorial Hospital.

**Dr. John Wikman**, a general surgeon from Fort Smith, has been elected vice chief of staff of Sparks Regional Medical Center.

## Physician's Recognition Award

The Physician's Recognition Award is awarded each month to physicians who have completed acceptable programs of continuing education. The recipients for the months of January and February are:

John W. Baker	Little Rock
James C. Bethel	Little Rock
Jay O. Brainard	Little Rock
Stanley W. Burleson	De Witt
Peter J. Carroll	El Dorado
Dennis O. Davidson	Batesville
John H. Delamore	Fordyce
John C. Dobbs	Conway
G. Lawrence Gunaway	Harrison
John H. Finck	Mena
Richard L. Hayes	Jacksonville
Burton A. Moore	Little Rock
Robert H. Nunnally	Camden
George V. Roberson	Pine Bluff
Victor A. Rozeboom	Harrison
Eugene A. Shaneyfelt	Manila
Robert F. Shannon	Little Rock
Louis G. Singleton	Little Rock
Sidney W. Tate	Searcy
Kenneth B. Turner	Russellville



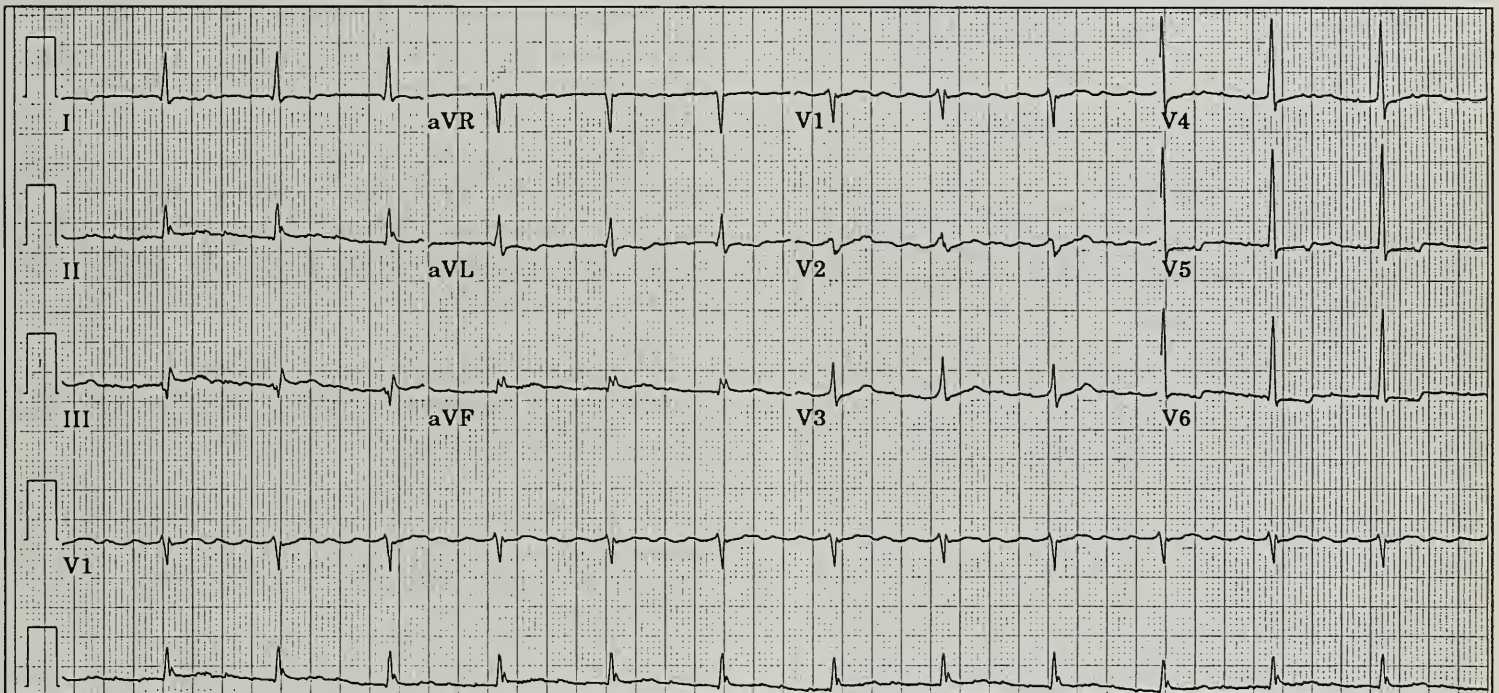


# Electrocardiogram of the Month

Jon P. Lindemann, M.D.  
UAMS Division of Cardiology  
Little Rock, Arkansas

## HISTORY:

This record was obtained from a 74-year-old who was receiving digitalis.



## DISCUSSION:

The underlying atrial mechanism is atrial fibrillation. Although regular waves at a rate of approximately 300 per minute appear in the precordial leads, the absence of a typical undulating saw-tooth pattern in the inferior leads (II, III, aVF) precludes the diagnosis of atrial flutter. The QRS axis and QRS duration are normal indicating normal intraventricular conduction. The ST segments are mildly depressed with flattened or biphasic T waves in the lateral leads (I, aVL, and V5-V6). These are termed minor non-specific ST and T wave abnormalities. The most bothersome finding is that in spite of the presence of atrial fibrillation, the ventricular rhythm is regular. This indicates the presence of AV dissociation, due in this case to high degree AV block. The fact the QRS complexes are of normal contour and duration indicate a junctional or AV nodal origin of the complexes controlling the ventricles. The manifest rate of junctional depolarization, roughly 80 per minute, exceeds the normal junctional rate 40-60 per minute. Thus, an accelerated junctional rhythm is present. The combination of high degree AV block and acceleration of subsidiary pacemakers is a hallmark of digitalis excess.



# New Members

---

## BENTON COUNTY

**McCollum, William E.**, Psychiatry/Family Practice, Rogrs. Born, March 7, 1956, Little Rock. Medical education, UAMS, 1983. FP internship, University of Oklahoma School of Medicine, Tulsa, 1984. FP residency, University of Oklahoma School of Medicine, Bartlesville, 1986. Psy residency, University of Oklahoma College of Medicine, Tulsa, 1991. Practice experience, 5 years. Board certified, Family Practice; board eligible, Psychiatry.

## CRAIGHEAD/POINSETT COUNTY

**Ricca, Dallie F.**, Anesthesiology, Jonesboro. Born, December 23, 1957, Buffalo, NY. Medical education, East Tennessee State University, Johnson City, 1983. Internship, Grady Memorial Hospital, 1984. Residency, University of Tennessee Affiliated Hospitals, Memphis, 1988. Board eligible.

## MILLER COUNTY

**Desrochers, Paul E.**, Psychiatry, Texarkana. Born, December 7, 1929, Quebec, Canada. Medical education, Laval University, Quebec, Canada, 1957. Internship/residency, Ottawa Ontario, Canada, 1971. Board certified.

**Robertson, William J.**, OB/GYN, Texarkana. Born, October 14, 1951, Warren. Medical education, UAMS, 1989. Internship/residency, University Hospital, Little Rock, 1981. Board certified.

## POPE COUNTY

**Goodman, Robin Q.**, Pediatrics, Russellville. Born, March 6, 1956, Fort Smith. Medical education, UAMS, 1982. Internship/residency, William Beaumont Army Medical Center, 1985. Board certified.

## PULASKI COUNTY

**Bitzer, Lon G.**, General Surgery, Little Rock. Born, April 9, 1959, Edwards, CA. Medical education, University of California College of Medicine, Irvine, 1985. Internship/residency, State University of New York, 1991. Board eligible.

**Christiansen, Stephen P.**, Pediatric Ophthalmology, Little Rock. Born, September 11, 1956, Pontiac, MI. Medical education, Medical College of Wisconsin, Milwaukee, 1982. Internship, Eastern Virginia Graduate School of Medicine, 1983. Residency, University of Kentucky, 1990.

**Freeman, Diane H.**, Pediatrics, Little Rock. Born, October 21, 1958, San Antonio, TX. Medical education, University of Texas Medical School, Houston, 1985. Internship/residency, University of Texas Medical School, Houston, 1988. Board certified.

**Garst, Neema A.**, Family Medicine, Little Rock. Born, May 5, 1952, India. Medical education, Christian Medical College, Ludhiana, India, 1974. Internship/residency, UAMS, 1981. Board certified.

**Good, David M.**, Psychiatry, Little Rock. Born, February 15, 1954. Board certified.

**House, Aniel H.**, General Practice, North Little Rock. Born, September 7, 1951, Little Rock. Medical education, UAMS, 1973. Internship/residency, UAMS, 1979.

**Jones, Sherman M.**, Rheumatology/IM, Little Rock. Born, September 16, 1958, New Orleans, LA. Medical education, LSU Medical College, Shreveport, 1986. Internship/residency, UAMS, 1989. Board certified.

**Sexton, Jon A.**, Pulmonary Medicine, Little Rock. Born, October 31, 1954, Newcastle, IN. Medical education, University of Kansas Medical Center, Kansas City, 1985. Internship/residency, University of Kansas Medical Center, Kansas City, 1991. Board certified.

**Verma, Virendar K.**, Physical Medicine & Rehabilitation, Jacksonville. Born, July 20, 1948, India. Medical education, Jawahar Lal Nehru Medical College, Delhi, India, 1972. Internship/residency, Jawahar Lal Nehru Medical College, Delhi, India; All India Institute of Medical Sciences, Delhi, India; Kingsbrook Jewish Medical Center, Brooklyn, NY, 1982. Board certified.

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## MEMBERS-AT-LARGE

### Helena

**Tan, Benjamin S.**, General & Thoracic Surgery. Born, February 6, 1932, Philippines. Medical education, Far Eastern University School of Medicine, Manila, Philippines, 1958. Internship, Mt. Sinai Hospital, Cleveland; Sinai Hospital, Baltimore, 1959. Residency, Creighton University; Sinai Hospital, Baltimore; University of Tennessee; St. Vincent Hospital, Cleveland, 1967. Board eligible.

### Paragould

**Morrison, Jimmy J.**, Gastroenterology. Born, September 21, 1960, Malvern. Medical education, LSU Medical Center, 1985. Internship/residency, UAMS, 1991. Board certified.

## RESIDENT PHYSICIAN SECTION

**Le, Dung N.**, Family Practice, Pine Bluff. Born, October, 4, 1953, Vietnam. Medical education, Louisiana State University School of Medicine, Shreveport, 1989. Internship, E.A. Conway Memorial Hospital, Monroe, LA, 1989. Residency, UAMS.

# In Memoriam

### J.T. Dobson, M.D.

Dr. J.T. Dobson, a Fordyce physician, died Friday, April 3, 1992. He was 65.

Dr. Dobson was a member of the Arkansas Medical Society, Arkansas Academy of Family Practice, and a Fellow of the American Academy of Family Practice.

Survivors are his wife, JoAnne Fincher Dobson; a son, Allen Cole Dobson of North Little Rock; a daughter, Dawn Elizabeth Dobson of Little Rock; a brother, Dr. Harold L. Dobson of Bellaire, TX; a sister, Martha Smith of Deer Park, TX; and a grandchild.

### Mrs. Jamie Ketz

Mrs. Jamie Frances Barnett Ketz, of Batesville, died Wednesday, April 1, 1992.

Mrs. Ketz is survived by her husband, Dr. Wesley J. Ketz; two sons, Wesley J. "Butch" Ketz Jr. of Batesville and Charles F. "Rusty" Ketz of Dallas; a sister, Mrs. Preston Grace of Batesville; and two grandchildren.

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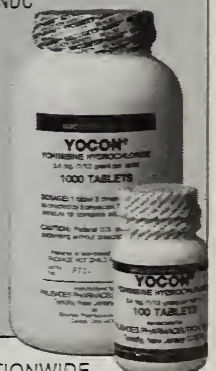
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### References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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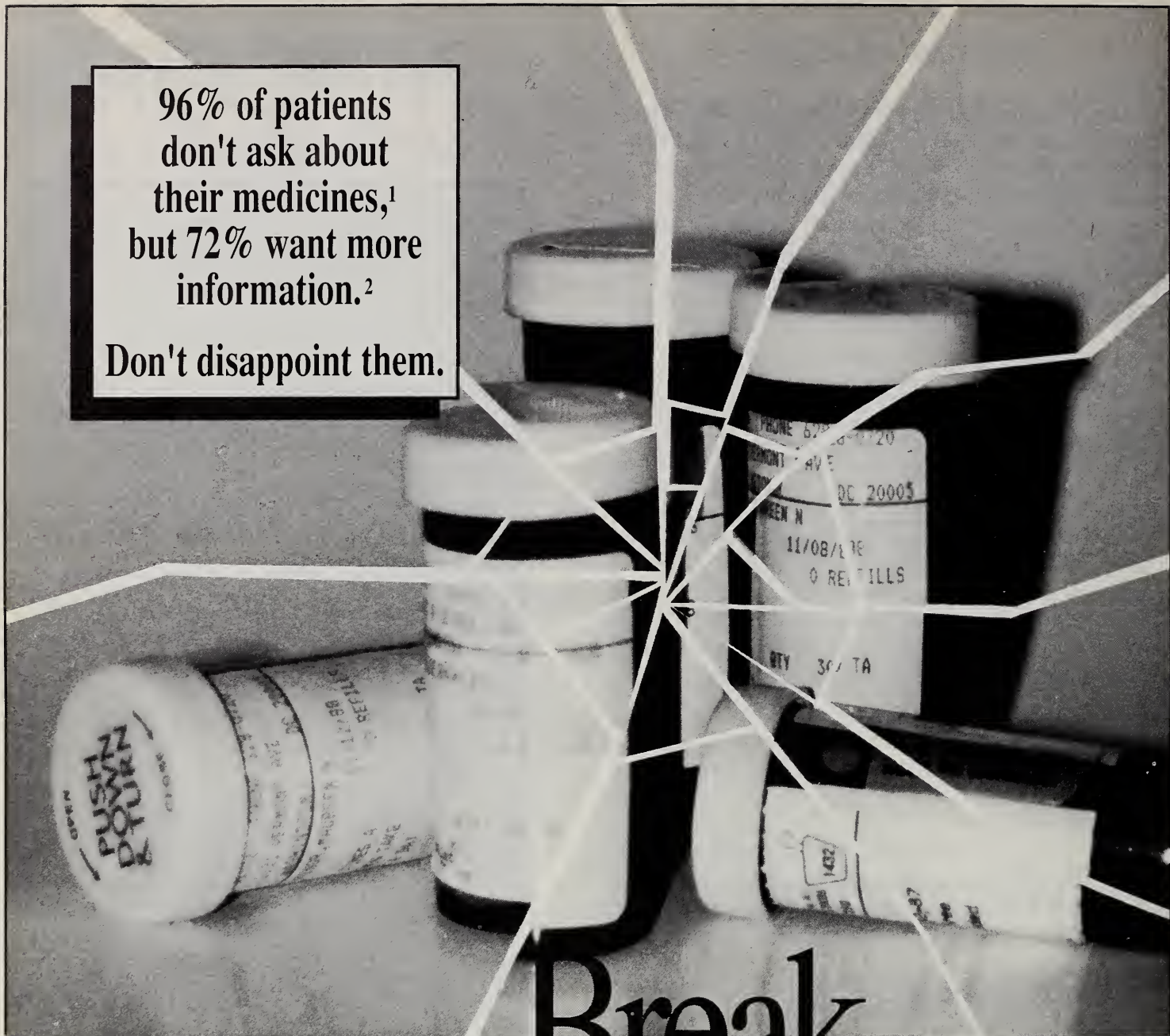
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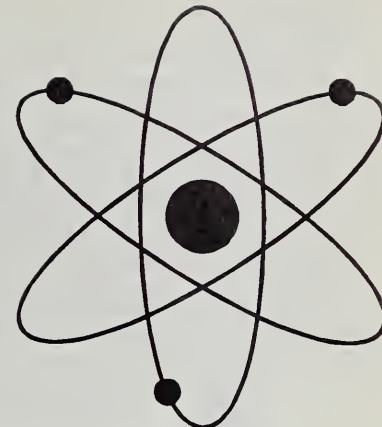
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<sup>1</sup> FDA survey, "Patient Receipt of Rx Drug Information", 1983

<sup>2</sup> A Study of Attitudes, Concerns, and Information Needs for Rx Drugs  
and Related Illnesses, CBS Television Network Consumer Model Survey, 1983

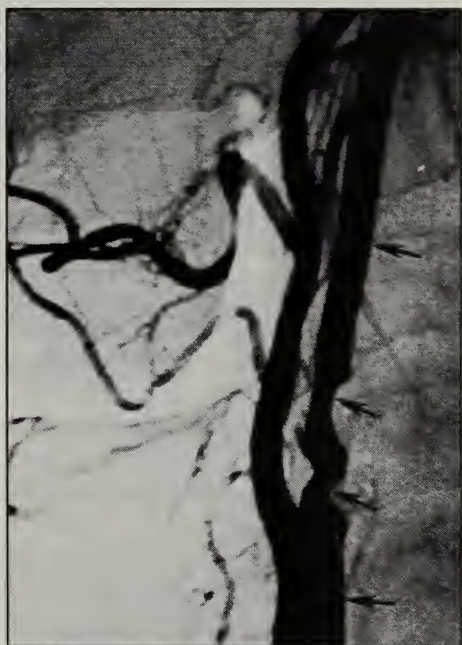


# Radiological Case of the Month

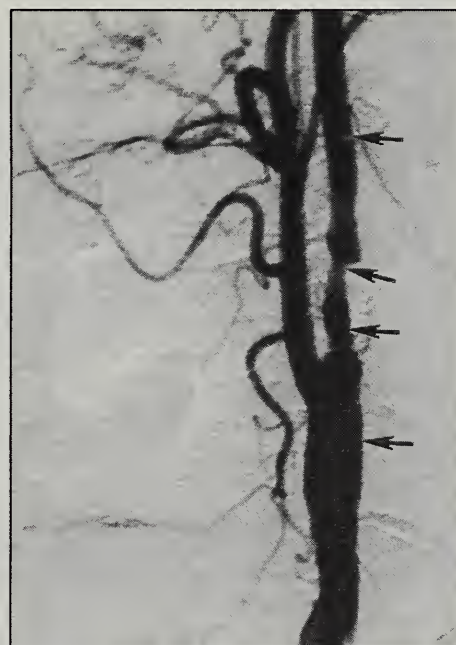


Timothy J. Ranval, M.D.  
Maurice M. Solis, M.D.  
Robert W. Barnes, M.D.  
David McFarland, M.D.  
David Harshfield, M.D.

What is the percent stenosis?



*Figure 1. Left carotid, oblique view.*



*Figure 2. Left carotid, lateral view.*



## Discussion:

Many methods have been proposed for measuring the degree of stenosis secondary to atheromatous disease at the carotid bifurcation. The advantages and disadvantages as well as intra- and inter-observer variability have been explored and can be argued.<sup>1-3</sup> The prospective, randomized studies on extracranial carotid artery disease have used percent diameter reduction as the angiographic criteria for stratification of patients.<sup>4,7</sup> These studies will most likely determine the indications for surgery in the future and as such the angiographic criteria will be diameter reduction comparing the narrowest residual lumen to the distal internal carotid artery.

With slight modifications, each method specifies using the single best view of the stenosis. Diameter measurements are taken of the minimum residual lumen (MRL) and the distal lumen (DL) of the extracranial internal carotid artery distal to the disease and post stenotic dilatation (PSD) where the wall of the internal carotid artery appear parallel. The percent stenosis is then calculated:

$$1 - \frac{\text{MRL}}{\text{DL}} \times 100\% = \% \text{ Stenosis}$$

In our example using the lateral view, the formula would be:

$$1 - \frac{3.5 \text{ mm}}{7.0 \text{ mm}} \times 100\% = 50\% \text{ Diameter}$$

Had an area stenosis (instead of diameter) been calculated using two views and the common carotid artery diameter as a reference, the calculated cross sectional area stenosis could be calculated as high as 90%.

Obviously, one number is a percent diameter stenosis and the other is a percent area stenosis, however, using a 70% diameter "stenosis" as a threshold for operation (NASCET criteria for symptomatic lesions)<sup>7</sup> this person does not meet the criteria for carotid endarterectomy.

In view of the reported and ongoing extracranial vascular disease studies all reports should include diameter reduction using the above formula as the preferred method. For clarity, reporting the percent stenosis and specifying the method used to calculate the percent stenosis will avoid any confusion should a question of appropriateness of therapy be raised.

## References

1. Brown PM, Johnson KW. The difficulty of quantifying the severity of carotid stenosis. *Surgery* 1982; 92:468-73.
2. Chikos PM, Fisher LD, Hirsch JH, Harley JD, Thiele BL, Strandness DE. Observer variability in evaluating extracranial carotid artery stenosis. *Stroke* 1983; 14:885-92.
3. Karkow WS, Cranley JJ. Variations in interpretation of arterial stenosis. *J Cardiovasc Surg* 1989; 30:826-32.
4. Veterans Administration Cooperative Study. Role of carotid endarterectomy in asymptomatic carotid stenosis. *Stroke* 1986; 17:534-39.
5. The Asymptomatic Carotid Atherosclerosis Study Group. Study design for randomized prospective trial of carotid endarterectomy for asymptomatic atherosclerosis. *Stroke* 1989; 17:844-49.
6. The CASANOVA Study Group. Carotid surgery versus medical therapy in asymptomatic carotid stenosis. *Stroke* 1991; 22:1229-35.
7. North American Symptomatic Carotid Endarterectomy Trial Collaborators. Beneficial effect of carotid endarterectomy in symptomatic patients with high-grade stenosis. *NEJM* 1991; 325:445-53.

Editor: David Harshfield, M.D., chief of the radiology service at the Veterans Administration Hospital in Little Rock, and director of radiology at Riverside Radiologist Group in North Little Rock.

Contributor: Timothy J. Ranval, M.D., is a Vascular Surgery Fellow with the University of Arkansas for Medical Sciences and John L. McClellan Veterans Memorial Hospital, Little Rock.

Contributor: Maurice M. Solis, M.D., is a Vascular Surgery Fellow with the University of Arkansas for Medical Sciences and John L. McClellan Veterans Memorial Hospital, Little Rock.

Contributor: Robert W. Barnes, M.D., is professor and chairman of General Surgery at the University of Arkansas for Medical Sciences.

Contributor: David McFarland, M.D., is head of the Angiography Section at the University of Arkansas for Medical Sciences.

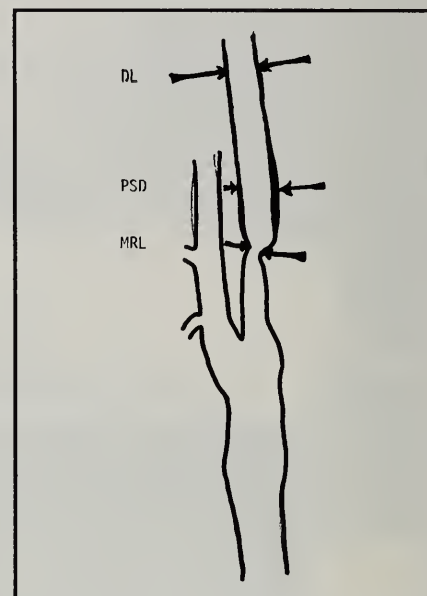


Figure 3. Schematic lateral view of carotid stenosis showing the Minimum Residual Lumen (MRL), Post Stenotic Dilatation (PSD), and the site of the Distal Lumen (DL) where measurement is taken to derive the percent diameter reduction. (Stenosis)



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WORKMAN'S COMP

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REFERRING PHYSICIAN SECONDARY

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PLACE OF SERVICE CODE

PRIMARY CARRIER

PRIOR AUTHORIZATION

TYPE OF SERVICE CODES

SAME/SIMILAR INDICATOR

PATIENT CHARTS DAY SHEETS

SUPERBILL

CPT PROCEDURE CODES

WAITING

LEDGER CARDS

WRITE-OFF

PARTICIPATING PHYSICIAN

ROOM

INSURANCE CARDS

GROUP POLICY NUMBER

CHARGE SLIPS

MEDICARE

DISABILITY

PATIENT STATEMENTS

RELATIONSHIP TO THE INSURED

PAYMENT

APPROVED AMOUNT

AMOUNT

TYPEWRITER

CODING REQUIREMENTS

APPOINTMENT BOOK

EXAMINATION ROOM

TICKLER FILES

DATE OF DISABILITY

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MEDICAID

ATTENDING PHYSICIAN PPO/HMO

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# Medicine in the News

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## Health Care Access Foundation Update

As of April 1992, the Arkansas Health Care Access Foundation has provided free medical services to 3,767 medically indigent persons.

The program has 1,462 volunteer health care providers including medical doctors, dentists, hospitals, home health agencies, and pharmacists. These providers have rendered free treatment in 67 of the 75 counties.

## Little Rock Doctor Completes Medical Mission to Bangladesh

Ophthalmologist Dr. Charles Henry of Little Rock recently returned from a one-week medical skills exchange program in Dhaka, Bangladesh, where he demonstrated eye surgery techniques for local eye doctors and other medical professionals.

Dr. Henry, a Glaucoma specialist, volunteered as a visiting faculty member of ORBIS International, a humanitarian organization which fights blindness across the world by offering hands-on medical training to doctors, nurses, biomedical technicians, and community health workers. This most recent mission was Dr. Henry's second, he previously participated in an ORBIS mission lecturing in Ecuador in 1991.

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## CME Speakers Needed in Virgin Islands

The U.S. Virgin Islands is a very small medical society. There are only two CME sponsors, the St. Croix Hospital and the St. Thomas Hospital. Both hospitals have very well-organized, active CME Committees. However, they are having difficulty obtaining qualified speakers for their CME programs.

A number of state chairpersons have indicated that many qualified physicians vacation in the Virgin Islands each year. They stated that they would no doubt be very happy to give a CME lecture, as per ACCME provisions.

If anyone is interested, please call Dr. Angelo Galiber, St. Croix Hospital staff CME director, at (809) 778-5305 or Dr. Brian Cheetham, St. Thomas Hospital CME chairman at (809) 774-1080.

## Barrett-Tuck Scholarship Established

An alumna of Arkansas State University and her husband are establishing a new scholarship fund to benefit a deserving student majoring in one of the fields of science at ASU.

Dr. Rebecca Barrett-Tuck of Jonesboro, a 1978 graduate of ASU, and her husband, Sam Tuck, have already contributed a major portion of the \$25,000 needed to endow the scholarship.

The scholarship award criteria provides that each recipient will be a student from an underprivileged background who has earned at least a 3.0 grade point during his/her freshman year at ASU.

The first recipient of the scholarship will be named after the fund has grown to the level of full endowment.

Dr. Barrett-Tuck is a neurosurgeon with Neurosurgical Associates of Northeast Arkansas in Jonesboro.

## Forrest City Clinic Wins Quality Council Grant

The Arkansas Quality Council recently awarded a \$1,000 grant to The Women's Clinic, a women's health care clinic in Forrest City owned by Dr. James DeRossitt III, to help improve their quality or customer service programs.

In its first year, the Council's grant program was designed to help small Arkansas businesses with less than 75 employees improve their quality programs.



According to Dr. DeRossitt, "The clinic hopes to serve as a model for area health care offices by implementing quality management techniques and thus providing better care for our patients." The clinic has eight employees.

The Arkansas Quality Council is a non-profit organization dedicated to helping Arkansas companies become more competitive by advancing the quality sciences and quality improvement initiatives.

The Council will award additional grants in October. For more information about the grant program, contact Mr. David Money at (501) 882-6452.

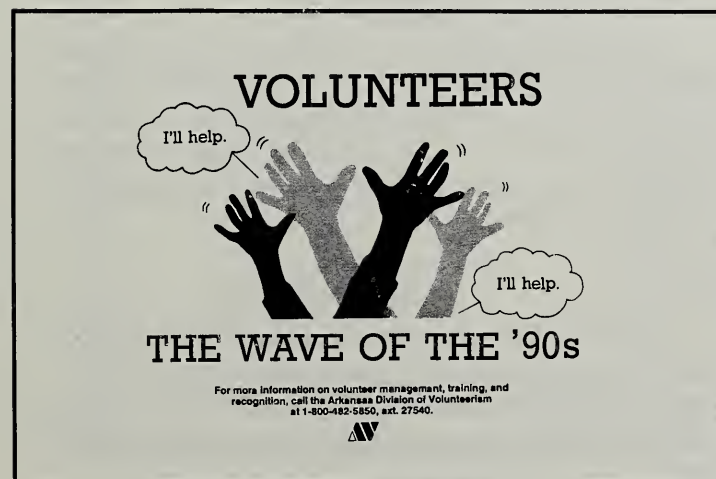
## **\$13,000 Raised for Orthopaedic Research in Arkansas**

Dr. Banks Blackwell of Pine Bluff and Dr. John B. McGinty have announced the record-breaking results of the 1991 Campaign for the Future of Orthopaedic Surgery. Just over \$3.8 million was raised in this nationwide campaign, and \$3.7 million was immediately allocated to fund 79 new grants - the most ever in the 36 year history of the Orthopaedic Research and Education Foundation.

Under Dr. Blackwell's direction, five of the state's orthopaedists - Robert Gullett Jr., M.D., Pine Bluff; James Kolb, M.D., Russellville; Bruce Smith Jr., M.D., Pine Bluff; John Wilson, M.D., Little Rock; and John Vander Schilden, M.D., Little Rock - led the volunteer effort to solicit their colleagues to join the Order of Merit with contributions of \$1,000 or more. They enrolled 12 of their fellow orthopaedic surgeons and raised \$13,000.

The Orthopaedic Research and Education Foundation offers an extensive program of individual, departmental, institutional and society grants and awards.

For further information and applications, call Katherine Walker, Director of Grants, OREF, (708) 698-9980.



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Author information should include titles, degrees, and any hospital or university appointments of the author(s). All scientific manuscripts must include an abstract of not more than 100 words. The abstract is a factual summary of the work and precedes the article. Manuscripts should be typewritten, double-spaced, and have generous margins. Subheads are strongly encouraged. The original and one copy should be submitted. Pages should be numbered. Manuscripts are not returned; however, original photographs or drawings will be returned upon request after publication. Manuscripts should be no longer than ten typewritten pages. Exceptions will be made only under most unusual circumstances.

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Illustrations should be professionally drawn and/or photographed. Glossy black and white photos are preferred. They should not be mounted and should have the name of the author(s) and figure number penciled lightly on the back. An arrow should indicate the top of the illustration. In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material. Up to four illustrations will be accepted at no charge to the author(s). If more than four are necessary, it is understood that the author(s) will be responsible for the reproduction costs.

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# Things To Come

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## May 30

**Regression of Coronary Artery Disease.** Cancer Center Auditorium, University of California Davis Medical Center, Sacramento. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: to be announced. Category I credits available. For more information, call (916) 734-5390.

## June 4-7

**Advances in Aesthetic & Reconstructive Breast Surgery.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## June 11-13

**Cornea & Contact Lens Conference.** The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## June 14-19

**Fingers to the Toes: Primary Care Orthopaedics.** Stanford Sierra Camp, Fallen Leaf Lake, CA. Sponsored by the University of California Davis Medical Center, Sacramento. Fees: \$510 physician; \$370 other. Category I, AAFP, and ACEP credits available. For more information, call (916) 734-5390.

## June 26-28

**Frontiers in Endourology.** Sponsored by and held at the Washington University Medical Center, St. Louis, MO. For more information, contact Cathy Caruso at 1-800-325-9862 or (314) 362-6893.

## June 29-July 3

**Origins of Coping with Stress.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

## July 6-10

**Behavioral Medicine Applications.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

## July 13-14

**2nd Annual Meeting of the SAGM.** Royal Garden Hotel, London, England. Sponsored by the Southern Association for Geriatric Medicine. For more information, call (205) 945-8425 or 1-800-423-4992.

## July 13-17

**Psychopharmacology Update.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

## July 13-17

**Multiple Family Group Therapy for Abuse.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

## July 16-17

**2nd Annual Meeting of the SAGM.** Hotel Sofitel, Lyon, France. Sponsored by the Southern Association for Geriatric Medicine. For more information, call (205) 945-8425 or 1-800-423-4992.

## July 20-24

**Personality and Political Behavior.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.

## July 26-30

**Current Concepts in Cardiology.** Hyatt Regency Lake Tahoe, Incline Village, NV. Sponsored by the Office of CME and the University of California Davis Medical Center, Sacramento. Fees: to be announced. Category I credits available. For more information, call (916) 734-5390.

## July 27-31

**Learning Disorders in Childhood and Adolescence.** Sponsored by and held at the Cape Cod Institute, Albert Einstein College of Medicine, Bronx, NY. Fees: \$395. For more information, call (212) 430-2307.



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Sponsored by the College of Medicine at the University of Arkansas for Medical Sciences. Category I credit hours available. Fees: \$75.00; \$55.00, VA employees. For more information, call Cindy Reid at 686-5261.

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## **Recurring Education Programs**

*As organizations accredited for continuing medical education by the Arkansas Medical Society, the organizations named certify that these continuing medical education activities meet the criteria for the credit hours specified in Category I of the Physician's Recognition Award of the American Medical Association.*

### **HOT SPRINGS-AMI NATIONAL PARK MEDICAL CENTER**

*CME Luncheon, 2nd & 4th Fridays, 12:30 p.m. AMI Ozark/Quapaw room. One Category I credit per meeting.*

### **FAYETTEVILLE - VA MEDICAL CENTER**

*Medical Conference (varying topics), 3rd Wednesday, 12:30 p.m., conference room, Bldg. 1, VAMC*

*Medical Grand Rounds, Fridays, 12:00 noon, VAMC*

### **LITTLE ROCK-ARKANSAS CHILDREN'S HOSPITAL**

*Faculty Resident Seminar, 3rd Thursday, 12:00 noon, Sturgis Auditorium*

*Genetics Conference, Wednesdays, 12:00 noon, Sturgis Bldg., room 457*

*Infectious Disease Conference, 2nd Wednesday, 12:00 noon, 2nd Floor Classroom*

*Pediatric Grand Rounds, Tuesdays, 8:00 a.m., Sturgis Bldg., Auditorium*

*Pediatric Neuroscience Conference, 1st Thursday, 8:00 a.m., 2nd Floor Classroom*

*Pediatric Pharmacology Conference, 5th Wednesday, 12:00 noon, 2nd Classroom*

*Pediatric Research Conference, 1st Thursday, 12:00 noon, 2nd Floor Classroom*

### **LITTLE ROCK-ST. VINCENT INFIRMARY MEDICAL CENTER**

*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., Southwestern Bell/Arkla room. Refreshments provided*

*Journal Club, Tuesdays, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided*

*Chest Conference, 2nd & 4th Wednesday, 12:00 noon, Southwestern Bell/Arkla room. Sandwich buffet served*

*Joint Tumor Conference, 1st Wednesday, 12:00 noon. CARTI Auditorium. Lunch provided*

*GYN Surgery Cancer Conference, 2nd Monday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided*

*Hematology-Oncology Conference, 2nd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided*

*Cancer Center Team Conference, 3rd Thursday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided*

*Sleep Disorders Case Conference, every other Thursday, Sleep Disorders Center conference room. Lunch provided*

*Interdisciplinary AIDS Conference, 2nd Friday, 12:00 noon, Southwestern Bell/Arkla room. Lunch provided*

### **LITTLE ROCK-BAPTIST MEDICAL CENTER**

*Anesthesiology Conference, 3rd Thursday, 7:00 a.m., conference room 1*

*GI Conference, 4th Friday, 12:00 noon, conference room 1*

*Grand Rounds Conference, Wednesdays, 12:00 noon, Shuffield Auditorium. Lunch provided*

*Pathology Conference, 1st Tuesday, 3:00 p.m., Pathology Library*

*Pediatric Grand Rounds, Tuesdays, 12:00 noon, Especially for Women Resource room, 2nd floor/BMC. Lunch provided.*

*Category 1 credits available.*

*Pulmonary Conference, Tuesdays, 12:00 noon, Shuffield Auditorium. Lunch provided*

*Sleep Case Conference, Fridays, 12:00 noon. Call BMC ext. 1902 for location. Lunch provided*



## **NORTH LITTLE ROCK-BAPTIST MEMORIAL HOSPITAL**

*Medicine Case Conference, 1st Wednesday, 12:00 noon, Assembly room*  
*Surgery Case Conference, 2nd Wednesday, 12:00 noon, Assembly room*  
*Chest Case Conference, 3rd Wednesday, 12:00 noon, Assembly room*  
*X-ray Case Conference, 4th Wednesday, 12:00 noon, Assembly room*

*As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the University of Arkansas for Medical Sciences certifies the following continuing medical education activities meet the criteria for Category I of the Physician's Recognition Award of the American Medical Association.*

## **LITTLE ROCK - UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES**

*ACRC Oncology Forum, Thursdays, 4:00 p.m., UAMS ACRC 2nd Floor Board room, 1.5 credits*  
*Anesthesia Lecture Series, Wednesdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B*  
*Anesthesia Morbidity & Mortality Conference, Tuesdays, 6:45 a.m.; 2nd & 4th Thursdays, 4:00 p.m., UAMS Education Bldg., room G/110 A&B*  
*Arkansas Blood & Cancer Society Conference, 6th Thursday, 7:30 p.m. Terrace Restaurant, Little Rock*  
*Cardiology Clinical Conference, Mondays, 4:00 p.m., UAMS, room 3S06*  
*Cardiology Graphics Conference, Wednesdays, 12:00 noon, UAMS, room 3S06*  
*CARTI North Tumor Board Cancer Conference, 2nd Wednesday, 12:00 noon, CARTI North, Searcy*  
*Cardiothoracic Surgery Conference, date, time, & location varies*  
*Cardiothoracic Surgery Monthly Journals Club, 4th Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D*  
*Cardiothoracic Surgery Morbidity & Mortality Conference, 2nd Saturday, 9:30 a.m., UAMS Surgery Dept. Library, room 2S/28D*  
*Child Psychiatry Update/Case Conference, 3 Fridays per month, 1:00 p.m., ACH Child Study Center conference room*  
*CME Outreach Program, dates, times & locations vary*  
*Emergency Medicine Didactic Conference 1, Thursdays, 12:00 noon. UAMS Education Bldg., room G/110A&B*  
*Emergency Medicine Didactic Conference 2, Thursdays, 1:00 p.m., UAMS Education Bldg., room G/110A&B*  
*Emergency Medicine Grand Rounds 1, Tuesdays, 3:00 p.m., UAMS Education Bldg., room B/106A&B*  
*Emergency Medicine Grand Rounds 2, Tuesdays, 4:00 p.m., UAMS Education Bldg., room B/106A&B*  
*Endocrinology Case Conference, Fridays, 7:30 a.m., ACRC 3rd floor conference room*  
*Gastroenterology Grand Rounds, Thursdays, 4:00 p.m., Gastroenterology conference room, 3D29*  
*GI/Radiology Conference, Tuesdays, 8:00 a.m., UAMS Radiology conference room, M1/293*  
*Hematology/Oncology Fellow's Forum, Fridays, 8:15 a.m., ACRC Betsy Blass conference room*  
*Interhospital Urology Grand Rounds, 1st Tuesday, 5:30 p.m., St. Vincent Arkla/Bell room*  
*LR Cancer Conference, Wednesdays, 12:00 noon, UAMS ACRC conference room three times a month, CARTI Auditorium once a month*  
*LR Vascular Conference, time & date varies monthly, rotates between UAMS, SVI & BMC*  
*Medicine Grand Rounds, Thursdays, 12:00 noon, UAMS Education Bldg., Rom G/131A&B*  
*Med/Path Conference, 3rd or 4th Tuesday, 3:00 p.m., UAMS Shorey Bldg., room S/306*  
*Medicine Journal Club, alternate Thursdays, 7:30 a.m., ACC Medicine Clinic conference room*  
*Medicine Research Conference, Wednesdays (except 3rd), 4:30 p.m. UAMS Education Bldg. room B/135*  
*Neurology Clinical Case Conference, Thursdays, 8:00 a.m., rotates between VAMC-LR, UAMS, & ACH*  
*Neuropathology Conference, Thursdays, 9:15 a.m. VAMC-LR Pathology Dept. 1.25 credit hours*  
*Neuroradiology Conference, Wednesdays, 4:00 p.m., UAMS Neuroradiology conference room, M1/293*  
*Neuroscience Conference (Basic), Mondays, 8:00 a.m., UAMS 7D33*  
*Neuroscience Conference (Basic & Clinical), Wednesdays, 4:00 p.m., UAMS 7C*  
*Nervousurgery Journal Club, 2nd & 4th Thursdays, 8:00 p.m., 2 credit hours*  
*Neurosurgical Pathology Conference, Thursdays, 4:00 p.m., VAMC-LR Neuropathology conference room, 2E141*  
*OB/GYN Fetal Boards, 2nd Fridays, 8:00 a.m., ACH Sturgis Bldg.*  
*OB/GYN Grand Rounds, Wednesdays, 7:45 a.m., UAMS Education Bldg., room G/131B*  
*Ophthalmology Problem Case Conference, Thursdays, 4:00 p.m., UAMS AAC Eye Clinic, room 3/150, 2 credit hours*  
*Ophthalmology Residency Morning Lectures, Mondays, Wednesdays, Fridays, 7:30 a.m., UAMS Education Bldg., room G102*  
*Orthopaedic Basic Science Conference, Tuesdays, 8:00 a.m., UAMS Education Bldg., room B/135*  
*Orthopaedic Bibliography Conference, Tuesdays, 8:30 a.m., UAMS Education Bldg., room B/135, 1.5 credit hours*  
*Orthopaedic Fracture Conference, Tuesdays, 7:30 a.m., UAMS Education Bldg., room B/135*  
*Orthopaedic Grand Rounds, Tuesdays, 10:00 a.m., UAMS Education Bldg., room B/135*  
*Pathology Autopsy Conference, Wednesdays, 12:00 noon, VAMC-LR Morgue*  
*Psychiatry Grand Rounds, Fridays, 11:00 a.m., UAMS Child Study Center Auditorium*  
*Surgery Basic Sciences Conference, 1st Saturday, 7:30 a.m., ACRC 2nd floor conference room*  
*Surgery Grand Rounds, Saturdays, 8:30 a.m., ACRC 2nd floor conference room*  
*Surgery Morbidity & Mortality Conference, Saturdays, 9:30 a.m., ACRC 2nd floor conference room*  
*Surgery Resident Case Conference, Saturdays (except 1st), 7:30 a.m., ACRC 2nd floor conference room*



*Trauma Morbidity & Mortality Conference*, date & time varies monthly, ACRC 2nd floor conference room  
*Urology Adult Subject Oriented Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Basic Sciences Conference*, 2nd Tuesdays, 5:00 p.m., VAMC-LR, 4D resident office  
*Urology Clinical Didactic Conference*, 3rd Tuesday, 5:00 p.m., VAMC-LR, 4D  
*Urology Formal Teaching (Grand) Rounds*, once or twice monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Morbidity & Mortality Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pathology Conference*, once monthly, 5:00 p.m., VAMC-LR, 4D  
*Urology Pediatric Conference*, once monthly, 5:00 p.m., ACH Sturgis Bldg., Clinic 2  
*Urology Teaching Conference*, Wednesdays, 5:00 p.m., VAMC-LR, 4D  
*Uro-radiology Conference (Urologic Imaging)*, 1st Tuesdays, 5:00 p.m., UAMS Radiology conference room  
*VA Chest Conference (combined Surgical/Medical Chest Conference)*, Mondays, 12:15 p.m., VAMC-LR, room 2D109  
*VA Diagnostic Imaging Conference*, Monday-Thursday, 8:00 a.m., VAMC-LR Nuclear Medicine conference room, room 1D173  
*VA GREEC/Geriatric Research Conference*, Tuesdays, 4:00 p.m., VAMC-LR, room 2D109  
*VA Hematology/Oncology Conference*, Thursdays, 8:15 a.m., VAMC-LR Pathology conference room 2E142  
*VA Lung Cancer Conference*, Thursdays, 3:00 p.m., VAMC-LR, room 2E142  
*VA Medical Service Teaching Conference*, Thursdays, 8:00 a.m., VAMC-NLR, Bldg. 68 room 130  
*VA Medicine-Pathology Conference*, Tuesday, 2:00 p.m., VAMC-LR, room 2D109  
*VA Medicine Resident's Clinical Case Conference*, Fridays, 12:00 noon, VAMC-LR, room 2D08  
*VA Physical Medicine & Rehab Grand Rounds*, 4th Friday, 11:30 a.m., VAMC-NLR Bldg. 68, room 118 or Baptist Rehab Institute  
*VA Surgery Grand Rounds*, Thursdays, 12:45 p.m., VAMC-LR, room 2D109, 1.25 credit hours  
*VA Topics in Rehabilitation Medicine Conference*, 2nd, 3rd, & 4th Thursdays, 8:00 a.m., VAMC-NLR Bldg. 68, room 118  
*VA Weekly Cancer Conference*, Monday, 3:00 p.m., VAMC-LR, room 2E-142  
*White County Memorial Hospital Medical Staff Program*, once monthly, dates & times vary, White County Memorial Hospital, Searcy

## **EL DORADO - AHEC**

*Behavioral Sciences Conference*, 1st & 4th Friday, 12:30 p.m., AHEC - South Arkansas.  
*Chest Conference*, 3rd Wednesday, 12:30 p.m., Warner Brown Hospital  
*Gynecology-Pathology Conference*, 2nd Friday, 12:30 p.m., AHEC-South Arkansas  
*Internal Medicine Conference*, 1st, 2nd & 4th Wednesday, 12:30 p.m., AHEC-South Arkansas  
*Pathology Conference*, 2nd Tuesday, 12:15 p.m., AHEC-South Arkansas  
*Pediatric Conference*, last Monday, 12:30 p.m., AHEC - South Arkansas  
*Obstetrics-Gynecology Conference*, 4th Thursday, 12:30 p.m., AHEC-South Arkansas  
*Surgical Conference*, 1st, 2nd & 3rd Monday, 12:30 p.m., AHEC-South Arkansas  
*Tumor Clinic*, 4th Tuesday, 12:30 p.m., AHEC-South Arkansas

## **FAYETTEVILLE - AHEC NORTHWEST**

*AHEC Teaching Conferences*, Tuesdays & Wednesdays, 12:00 noon, Washington Regional Medical Center  
*AHEC Teaching Conferences*, Fridays, 12:00 noon, Fayetteville City Hospital  
*AHEC Teaching Conferences*, Thursdays, 7:30 a.m., Washington Regional Medical Center

## **FORT SMITH - AHEC**

*Gastroenterology Conference*, 3rd Tuesday every other month, 7:00 a.m., St. Edward Mercy Medical Center  
*Neuroradiology Conference*, 3rd Wednesday, 12:00 noon, St. Edward Mercy Medical Center

## **JONESBORO-AHEC NORTHEAST**

*AHEC Lecture Series*, 1st & 3rd Tuesday, 12:00 noon, Stroud Hall, St. Bernards Regional Medical Center. Lunch provided.  
*Arkansas Methodist Hospital CME Conference*, 7:30 a.m., Hospital Cafeteria, Arkansas Methodist Hospital, Paragould.  
*Chest Conference*, 2nd Tuesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided  
*Citywide Cardiology Conference*, 3rd Thursday, 7:30 p.m., Jonesboro Holiday Inn  
*Clinical Faculty Conference*, 5th Tuesday, St. Bernards Regional Medical Center, Dietary conference room, lunch provided  
*Craighead/Poinsett Medical Society*, 1st Tuesday, 7:00 p.m. Jonesboro Country Club  
*Eaker AFB CME Conference*, monthly, 12:00 noon or 4:00 p.m., Hospital Cafeteria  
*Independence County Medical Society*, 2nd Tuesday, 7:30 p.m., Batesville Country Club, Batesville  
*Interesting Case Conference*, 4th Tuesday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Jackson County Medical Society*, 3rd Thursday, 7:00 p.m., Newport Country Club, Newport  
*Kennett CME Conference*, 3rd Monday, 12:00 noon, Twin Rivers Hospital Cafeteria, Kennett, MO  
*Methodist Hospital of Jonesboro CME Conference*, 2nd Tuesday, 7:00 p.m., Cafeteria, Methodist Hospital of Jonesboro  
*Neuroradiology Conference*, 3rd Friday, 12:00 noon, St. Bernards Dietary conference room. Lunch provided.  
*Perinatal Conference*, 2nd Wednesday, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided.  
*Pocahontas CME Conference*, 3rd Wednesday, 12:00 noon & 7:30 p.m., Randolph County Medical Center Boardroom



*Tumor Conference, Thursdays, 12:00 noon, St. Bernard's Dietary conference room. Lunch provided*  
*Walnut Ridge CME Conference, 3rd & last Tuesday, 12:00 noon, Lawrence Memorial Hospital Cafeteria*  
*White River CME Conference, 3rd Thursday, 12:00 noon, White River Medical Center Hospital Boardroom*

#### **PINE BLUFF-AHEC**

*Behavioral Science Conference, 1st & 3rd Thursday, 12:00 noon, Jefferson Regional Medical Center*  
*Chest Conference, 2nd & 4th Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Family Practice Conference, 1st & 4th Tuesday, 12:00 noon, Jefferson Regional Medical Center*  
*Geriatrics Conference, 3rd Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Internal Medicine Conference, 2nd & 4th Wednesday, 12:00 noon, Jefferson Regional Medical Center*  
*Obstetrics/Gynecology Conference, 2nd Tuesday, 12:00 noon, Jefferson Regional Medical Center*  
*Orthopedic Case Conference, 2nd & 4th Thursday, 12:00 noon, Jefferson Regional Medical Center.*  
*Pediatric Conference, 3rd Wednesday, 12:00 noon, Jefferson Regional Medical Center*  
*Radiology Conference, 3rd Tuesday, 12:00 noon, Jefferson Regional Medical Center*  
*Southeast Arkansas Medical Lecture Series, 4th Tuesday, 6:30 p.m., Pine Bluff County Club. Dinner meeting.*  
*Surgery Conference, 1st Friday, 12:00 noon, Jefferson Regional Medical Center*  
*Tumor Conference, 1st Wednesday, 12:00 noon, Jefferson Regional Medical Center*

#### **TEXARKANA-AHEC SOUTHWEST**

*Cardiology Conference, Fridays, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center*  
*Chest Conference, 3rd Wednesday, 12:30 p.m., St. Michael Hospital.*  
*Internal Medicine Conference, 2nd Tuesday, 12:00 noon, alternates between St. Michael Hospital & Wadley Regional Medical Center*  
*Neuro-Radiology Conference, 2nd & 4th Tuesday, 12:00 noon, Wadley Regional Medical Center*  
*Surgeons Pathology Conference, 2nd Tuesday, 7:00 a.m. breakfast, Wadley Regional Medical Center*  
*Tumor Conference, 1st Wednesday, 7:00 a.m. breakfast, St. Michael Hospital*  
*AHEC Tumor Board, 1st through 4th Friday each month, 12:00 noon, alternates between Wadley Regional Medical Center & St. Michael Hospital*



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# The Journal of the Arkansas Medical Society

## Index 1991-1992

### Volume 88, Numbers 1-12

(O) Original Article; (SP) Special Article; (OB) Obituary; (R) Resolution; (E) Editorial

#### -A-

- A to B Approach to Investing (O) 566  
 Abel, Lee (E) 80, 433  
 Access to Health Care for Children and Adolescents (E) 264  
 AIDS in Arkansas  
     HIV: Risks to Health Care Workers and Risk Reduction (O) 94  
     Use of Hematopoietic Growth Factors in Patients with HIV Disease (O) 142  
     Recommendations for Preventing Transmission of HIV and HBV to Patients During Exposure-Prone Invasive Procedures (SP) 228  
     The Florida HIV Dental Case (O) 279  
     UAMS FATE Program Recognized by the AMA (O) 563  
 AIDS in Arkansas Statistics 60, 95, 140, 186, 232, 282, 350, 414, 452, 538, 564, 628  
 AMS Newsmakers 58, 100, 152, 194, 245, 290, 346, 416, 462, 526, 574, 630  
 Anxiety Disorders: Diagnosis and Treatment (O) 171  
 Arkansas Medical Society  
     116th Annual Session Program (SP) 478  
     Constitution and Bylaws (SP) 403  
     House of Delegates (SP) 27, 490  
     Inaugural Address (SP) 7  
     Membership Roster (SP) 363  
 Ashby, John W. (OB) 246  
 Ashcraft, Pamela (O) 382  
 Atkinson, Robert H. (OB) 463  
 Ault, Charles C. (OB) 155 (R) 248  
 Auxiliary, Arkansas Medical Society  
     68th Annual Session Program (SP) 480  
     Convention Report (SP) 51  
     Program Information for the 68th Annual Session (SP)  
 Avery, J. Kelley (O) 92, 234, 446

#### -B-

- Barnes, Robert W. (O) 215  
 Beck, Joseph M. (O) 142  
 Becton, David (O) 382  
 Berglund, Scott (O) 569  
 Biomedical Research at UAMS (E) 212  
 Bowles, Mark H. (O) 175  
 Branch Jr., James W. (OB) 246  
 Breast Milk, Pesticide Concentrations in Arkansas (O) 553  
 Brewster, Marge A. (O) 553

#### -C-

- Car Restraint Device Use Among Young Children, Involvement of Arkansas Hospitals in Promotion in, (O) 601  
 Carcinoma, Coughing Up of Metastatic Tumor as the Initial CARE Report on Health Care Services (SP) 127  
 Carver, Danna K., (O) 215  
 Case for the Single Case Report (E) 124  
 Chamberlain, Joe W. (OB) 418  
 CHAR Proposal Makes State Less Fertile Ground to Recruit Young Smokers (SP) 611  
 Cholecystectomy, Laparoscopic Laser (O) 83  
 Choosing an Investment Broker (O) 449  
 Clinical Manifestation of Renal Cell (O) 86  
 Coleman, Mary Ann (O) 130  
 Combined Raz Urethral Suspension and McGuire Pubovaginal Sling for Treatment of Complicated Stress Urinary Incontinence (O) 389  
 Conkle, Cindy (O) 284  
 Coronary Angioplasty, Efficacy of Dextran Therapy in (O) 175  
 Cost of Waiting (O) 621  
 Coughing Up of Metastatic Tumor as the Initial Clinical Manifestation of Renal Cell Carcinoma (O) 86  
 CPT Evaluation and Management Codes, New (SP) 315

#### -D-

- DeLoach Jr., John M. (O) 83  
 Dermatitis, Evaluation of Contact Using the TRUE Patch Test (O) 271  
 Dilday, James "Kurt" (O) 171  
 Dilday, Thomas F. Jr. (OB) 463 (R) 534  
 Dobson, J.T., (OB) 633  
 Drange, Robert K. (OB) 197  
 Durham, Thomas M. (OB) 246

#### -E-

- Efficacy of Dextran Therapy in Coronary Angioplasty (O) 175  
 Elders, Joycelyn (E) 264  
 Electrocardiogram of the Month 68, 112, 156, 200, 236, 298, 357, 465, 535, 583, 631  
 Ellis, Eileen N. (O) 219  
 Evaluation of Contact Dermatitis Using the TRUE Patch Test (O) 271  
 Experience with the Kimray-Greenfield Inferior Vena Caval Filter (O) 215



## -F-

Faitak, Sarah (O) 553  
Fendley, Herb (O) 86  
Ferris, Ernest J. (O) 215  
Fertility Trends in Arkansas, 1980-88: An Analysis by  
Age, Marital Status, and Color (O) 135  
Fields, Mona Ray (O) 130  
Fournier, Donald C. (O) 279  
Fraser Jr., James H. (OB) 155 (R) 248  
Freeman, William H. (O) 86  
From Other Years  
James Issac Scarborough, M.D. (O) 146

## -G-

Gerberding, Julie L. (O) 94  
Golf CME Category I (O) 460  
Gray, Edwin F. (OB) 108 (R) 248  
Gray, Ruth F. (OB) 108

## -H-

Hamilton, Ralph B. (OB) 197  
Harris, Diana L. (O) 215  
Harris, Louise W. (OB) 246  
Harshfield, David (O) 460  
Health "Networking" (E) 168  
Henson, Kelton (O) 267  
Hlavaty, Tamara S. (O) 215  
Hogue, Alice M. (OB) 108  
Holt, L. Gordon (OB) 348 (R) 418  
How to Unveil Legislative Initiative (SP) 225

## -I-

Investing, The A to B Approach (O) 566  
Investing in Times Like These (O) 395  
Investment Broker, Choosing an (O) 449  
Involvement of Arkansas Hospitals in Promotion of  
Car Restraint Device Use Among Young Chil-  
dren (O) 601

## -J-

Jensen, Harold L. (O) 225  
Johnson, James A. (R) 248  
Jordan, Harry J. "Hank" (OB) 534

## -K-

Kelly, Nancy R. (O) 219  
Ketz, Jamie (OB) 633  
Knight, Mary Frances (OB) 155

## -L-

Lamb, Yvette (O) 553  
Laparoscopic Laser Cholecystectomy (O) 83  
Leavelle, Ray W. (OB) 463  
Legislative Initiative, How to Unveil (O) 225  
Lesh, Vincent O. (OB) 197

Long-Term Care Financing and Service Delivery:  
Meeting the Challenge in Arkansas (O) 559  
Loss Prevention Case Study  
A Missed Opportunity? (O) 234  
Asthma Increases its Number of Victims in the  
United States - and Some of Them are  
Physicians Sued for Malpractice (O) 398  
Changes in Society Have Affected the Relation-  
ship Between Physicians and Their Patients  
(O) 183  
Come to My Office in the Morning (O) 92  
Differences Between Medical Decisions and  
Moral Judgements Can Injure Patients and  
Sometimes Lead to Legal Hassles (O) 625  
Failure to Diagnose Myocardial Infarction (O) 284  
The Loser Finally Wins (O) 446  
To See Ourselves as Others See Us (O) 569  
Ludwig, Frank R. (O) 86

## -M-

May-Hughes, Krista (O) 559  
McCowan, Timothy C. (O) 215  
Medical Practice Guidelines, Ready or Not, Here  
They (Eventually) Come (E) 80  
Medicine, 1991: The Year in with Bold Predictions for  
1992 (E) 433  
Medicine in the News 66, 110, 198, 250, 294, 352, 464,  
528, 584, 638  
Metastatic Malignant Insulinoma: Debulking for  
Palliation of Symptoms (O) 267  
Metastatic Tumor, Coughing Up as the Initial Clinical  
Manifestation of Renal Cell Carcinoma (O) 86  
Mattison, Donald R. (O) 553  
Metzer, W. Steven (O) 607  
Miller, Phillip (O) 274  
Miller, Robert J. (O) 183, 398, 625  
Mills, Tom P. (O) 437  
Mitchell, George E. (OB) 463  
Mitchell, Michael W. (O) 89  
Murphy, Carmen (OB) 418

## -N-

New Members 59, 102, 148, 188, 238, 287, 244, 416,  
458, 527, 576, 632  
Newborn Screening for Hemoglobinopathies in  
Arkansas: First Two Years' Experience (O) 382  
Newton, Doane M. (OB) 463

## -O-

Occupational Health Nursing, Undergraduate  
Preparation (O) 130  
O'Donnell, Pat D. (O) 389  
Old Ledger Records Rural Doctor's Work (O) 276  
Olson, John (E) 124



### **-P-**

- Parkinson's Disease, Phenomenological Approach to the Correct Diagnosis of (O) 607  
Parsons, Earl (OB) 348  
Peeler, Malcom (OB) 108  
Pesticide Concentrations in Arkansas Breast Milk (O) 553  
Phenomenological Approach to the Correct Diagnosis of Parkinson's Disease (O) 607  
Physician Medical Records - Patient Access Revisited (O) 89  
Pregnancy, Substance Abuse and (E) 312  
Proteinuria in Children (O) 219

### **-R-**

- Radiological Case of the Month 63, 105, 149, 191, 241, 295, 353, 421, 455, 531, 579, 635  
Ramipril: A Review of the New Ace Inhibitor (O) 437  
Raney, Bascom P. (OB) 293  
RBRVS Medicare Physician Payment Reform-A New Era in Payment Practices (SP) 443  
Ready or Not, Hear They (Eventually) Come: Medical Practice Guidelines (E) 80  
Renal Cell Carcinoma, Coughing Up of Metastatic Tumor as the Initial Clinical Manifestation of (O) 86  
Resolutions 248, 418  
Robinette, Christie (O) 601  
Roundtree, Paul (O) 130  
Roy, Hampton (O) 617  
Rusher, A.H. (O) 267

### **-S-**

- Saltzman, Ben N. (E) 168, 598  
Santi, Lawrence L. (O) 135  
Schexnayder, Charlotte (O) 276  
Seventy Percent (70%) by '92 (E) 598  
Sherman, Robert L. (OB) 463 (R) 534  
Shultz, Sam (E) 312  
Selevan, Sherry G. (O) 553  
Smith, Graham (O) 395, 449, 566, 621  
Stair, J. Michael (O) 83  
Stanley, Scott (O) 563  
Subramanyam, Nanjunda S. (O) 86  
Substance Abuse and Pregnancy (E) 312  
Survey Underscores Changing Attitudes of Young Physicians (O) 274

### **-T-**

- To, Teresa (O) 553

### **-U-**

- UAMS, Biomedical Research at (E) 212  
Undergraduate Preparation for Occupational Health Nursing (O) 130

- Urinary Incontinence, Combined Raz Urethral Suspension and McGuire Pubovaginal Sling for Treatment of Complicated Stress (O) 389

### **-W-**

- Walking for Fitness and Fun (O) 617  
Walls, Edwina (O) 146  
Walls, Robert C. (O) 553  
West, Robert (O) 382, 601  
Where Have All The Patients Gone? (SP) 178  
White, Gloria (OB) 293  
Wilson, I. Dodd (E) 212  
Wohlleb, Jim (O) 553  
Woodward, Linda A. (O) 83  
Wright, R.W. (O) 271

## **Arkansas Medical Society Index of New Members 1991-1992**

### **-A-**

- Adkins, Kevin J. (Baxter) 188  
Alexander, Albert S. (Pulaski) 148  
Alexander, Arnold G. (Res.) 189  
Alexander, Eugene H. (Members-at-Large) 345  
Anthony, John L. (Res.) 102  
Anthony, Marianne N. (Res.) 59  
Archer, Robert L. (Members-at-Large) 288  
Ashe, Barbara E. (Boone) 576  
Asmar, Salomon N. (White) 102  
Astle, Nancy J. (Members-at-Large) 288  
Atiq, Omar T. (Jefferson) 344  
Augustine, Paul (Members-at-Large) 459

### **-B-**

- Bailey, Donald C. (Members-at-Large) 577  
Baker, Kevin G. (Res.) 189  
Barenbug, Andrew H. (Union) 576  
Barton, Gary M. (Pulaski) 188  
Baskin, Barry D. (Pulaski) 188  
Bass, Edward J. (Union) 102  
Beauchamp, Kermen D. (Ashley) 576  
Beck, M. Lowery (Craighead/Poinsett) 238  
Beland, Susan S. (Pulaski) 102  
Benton, William H. (Pulaski) 148  
Best, Timothy R. (Members-at-Large) 288  
Bienvenu III, Harold G. (Pulaski) 576  
Bise, Roger N. (Members-at-Large) 288  
Bitzer, Lon G. (Pulaski) 632  
Blackstock, Terri T. (Res.) 59  
Bolli, Jo-Ann T. (Res.) 59  
Boop, Frederick A. (Members-at-Large) 345  
Bourne, David E. (Members-at-Large) 345



Bradford, James D. (Pulaski) 287  
 Brineman, John R. (Pulaski) 287  
 Brown, Dennis R. (Craighead/Poinsett) 238  
 Brown, Hunter L. (Independence) 102  
 Brown, Peggy J. (Greene) 458  
 Builteman, Cynthia M. (Members-at-Large) 344  
 Burton, Anthony R. (Washington) 239

### -C-

Calleton, Richard L. (Members-at-Large) 239  
 Capps II, Dwight H. (Pulaski) 59  
 Carney, Stephen E. (Res.) 189  
 Casteel, Helen B. (Pulaski) 458  
 Chandler, Rodney R. (Members-at-Large) 459  
 Christiansen, Stephen P. (Pulaski)  
 Clark, Barbara J. (Members-at-Large) 239  
 Cohen, Jeffrey O. (Members-at-Large) 345  
 Cole, Evan D. (Res.) 189  
 Collins, Douglas J. (Res.) 102  
 Collins, Kimberly J. (Res.) 189  
 Cooper II, James K. (Res.) 189  
 Cope, Michael G. (Pulaski) 238  
 Craft, Charles W. (Sebastian) 189  
 Crit, Reon C. (Craighead/Poinsett) 344  
 Crosby, John C. (Res.) 577  
 Cunningham, Mark A. (Members-at-Large) 288  
 Curry, Janet F. (Members-at-Large) 288

### -D-

Daniels, Charles D. (Res.) 59  
 Davidson, Alice K. (Pulaski) 238  
 Davidson, Charles D. (Res.) 148  
 Davis, Brett C. (Pulaski) 287  
 Davis, Carole L. (Pulaski) 344  
 Desrochers, Paul E. (Miller) 632  
 DeYoung, Bruce (Res.) 189  
 Dobbs, John C. (Members-at-Large) 344  
 Doncer, Richard P. (Pulaski) 188  
 Donnell, Hugh G. (Benton) 238  
 Dow, John T. (Sevier) 576  
 Draughon, Edwin S. (Members-at-Large) 289  
 Dunn, Charles C. (Craighead/Poinsett) 238  
 Duplantis, Kathryn L. (Greene/Clay) 102

### -E-

Edgerton, Ada B. (Members-at-Large) 577  
 Eudy, Sidney F. (Members-at-Large) 345  
 Ewart, David V. (Benton) 148

### -F-

Fendly, Ann E. (Jefferson) 102  
 Ferguson, John S. (Clebune) 102  
 Filbeck, Kenneth J. (Res.) 189  
 Fine Jr., Bobbie D. (Members-at-Large) 576  
 Flaming, Jay A. (Members-at-Large) 577

Floyd, Dennis N. (Members-at-Large) 345  
 Floyd, Rebecca R. (Crawford) 188  
 Foster, Douglas C. (Benton) 238  
 Freeman, Diane H. (Pulaski) 632

### -G-

Garst, Neema A. (Pulaski) 632  
 Gately, Stanley E. (Pope) 188  
 Gerber, Allen D. (Members-at-Large) 458  
 Gist, Charles C. (Pulaski) 287  
 Good, David M. (Pulaski) 632  
 Goodman, Robin Q. (Pope) 632  
 Grear, Danna F. (Members-at-Large) 287  
 Grear, Tim (Members-at-Large) 287  
 Griffin, Nancy L. (Members-at-Large) 239

### -H-

Hagans II, James E. (Pulaski) 188  
 Haider, Riaz (Res.) 189  
 Hale, Kevin D. (Members-at-Large) 288  
 Harbin, Bradley (Lafayette) 188  
 Harris, Paul L. (Washington) 287  
 Harrison, Lonnie E. (Res.) 289  
 Harter, Scott B. (Pulaski) 576  
 Harvey, Bryan M. (Res.) 189  
 Hass, Farrell D. (Pope) 287  
 Hathcock, Stephen A. (Res.) 239  
 Haws, Karl W. (Res.) 189  
 Hayes, John M. (Pulaski) 148  
 Heiss, Nancy M. (Members-at-Large) 345  
 Henderson, Vickie L. (Res.) 148  
 Hoke, Wallace S. (Craighead/Poinsett) 458  
 Holland, Jerry M. (Members-at-Large) 344  
 Holland, Rhonda J. (Faulkner) 102  
 Hopson, Deanna L. (Members-at-Large) 459  
 Houchin, Vonda G. (Res.) 102  
 House, Aniel H. (Pulaski) 632  
 Houston, Samuel T. (Pulaski) 188  
 Huggins, David P. (Pulaski) 238  
 Hulsey, Matthew D. (Jefferson) 527  
 Humphreys, James D. (Members-at-Large) 288

### -I-

Ivy, Donald E. (Res.) 289

### -J-

Jain, Parker K. (Res.) 189  
 James, Janeen H. (Members-at-Large) 576  
 Jasin, Hugo E. (Members-at-Large) 288  
 Johnson, Carl L. (Pulaski) 59  
 Jones Jr., Charles W. (Pope) 238  
 Jones, Greg T. (Members-at-Large) 288  
 Jones, Sherman M. (Pulaski) 632  
 Jordan, Raymond (Res.) 189



**-K-**

Karlson, Karl H. (Members-at-Large) 288  
King, William D. (Pulaski) 287  
Klasson, Stephen C. (Res.) 289  
Klein Jr., E.F. (Pulaski) 287  
Klimberg, V. Suzanne (Pulaski) 238  
Knott, Patricia A. (Pulaski) 344  
Kozlowski, Karen J. (Pulaski) 238  
Kraichoke, Saran (Washington) 239  
Kramer, Thomas A. (Pulaski) 188

**-L-**

Lambert, James C. (Clebune) 238  
Landberg, Karl H. (Faulkner) 102  
Langston, James D. (Res.) 577  
Lavery, John P. (Members-at-Large) 288  
Le, Dung N. (Res.) 633  
Lefler, Stephen F. (White) 239  
Leonard, Stacy L. (Student) 577  
Letcher, Charles T. (Res.) 189  
Lile, Scott A. (Res.) 527

**-M-**

Manning, Robert D. (Members-at-Large) 345  
Marcus, Herschel C. (Jefferson) 458  
Martindale, Mark A. (Saline) 239  
Martinez, Luis H. (Pulaski) 188  
Marzewski, David J. (Members-at-Large) 577  
Mason, Richard H. (Members-at-Large) 287  
McCollum, William E. (Benton) 527  
McElroy, Kellye C. (Res.) 289  
McKenzie, James M. (Members-at-Large) 344  
Meadors, Frederick A. (Pulaski) 148  
Medlock, Rickey D. (Pulaski) 188  
Meeks, Connie A. (Members-at-Large) 288  
Meredith Jr., James T. (St. Francis) 416  
Mertz, John D. (Benton) 148  
Miers, Jane F. (Pulaski) 344  
Millstein, David I. (White) 239  
Mitchell, James Keith (Res.) 189  
Mizell, Philip L. (Members-at-Large) 288  
Moore, Donald J. (Members-at-Large) 289  
Morris, Barbara K. (Pulaski) 238  
Morrison, Jimmy J. (Members-at-Large) 633  
Morrison, Lynn C. (Pulaski) 102  
Morse, Michael W. (Members-at-Large) 288  
Mosley, Myra C. (Members-at-Large) 288  
Mullis, Ronald J. (Washington) 458  
Murphy, David S. (Pope) 344

**-N-**

Nayles, Lee C. (Members-at-Large) 344  
Neis, Paul R. (Baxter) 287  
Northam, Jon M. (Miller) 59  
Northam, Wanda M. (Miller) 576

**-O-**

Ohlhausen, Ward W. (Members-at-Large) 345  
Olive Jr., Robert James (Members-at-Large) 288

**-P-**

Padilla Jr., Jose S. (Boone) 458  
Parks, Greta (Pulaski) 59  
Patel, Madanmohan R. (Members-at-Large) 577  
Pevahouse, Joe B. (Pulaski) 148  
Phillips, Hannah M. (Pulaski) 148  
Pickett, Karen P. (Pulaski) 148  
Pickhardt, Mark G. (Members-at-Large) 458  
Pierce, William B. (Pulaski) 188

**-Q-**

Quinn II, John J. (Res.) 59  
Qureshi, Waqar A. (Res.) 189

**-R-**

Raben, Susan L. (Members-at-Large) 288  
Rahman, Holly E. (Res.) 289  
Rahman, Salim (Res.) 289  
Ramsey, D. Bruce (Res.) 458  
Ramsey, David B. (Members-at-Large) 345  
Ratcliff, David G. (Members-at-Large) 458  
Reddy, Krishna K. (Members-at-Large) 287  
Rommel, Raymond R. (Pulaski) 238  
Ricca, Dallie F. (Craighead/Poinsett) 632  
Ricca, Gregory F. (Craighead/Poinsett) 238  
Rice, James C. (Pulaski) 238  
Roberson, Charles D. (Cross) 344  
Robert, Magdalene S. (Members-at-Large) 287  
Robertson, William J. (Miller) 632  
Rodgers, H. Lynn (Benton) 188  
Ruddell, Deanna N. (Res.) 102  
Rutherford, Reginald (White) 576

**-S-**

SanPedro, Gerry S. (Members-at-Large) 345  
Sarnicki, Joseph D. (Union) 102  
Sayre, John C. (Howard/Pike) 576  
Schauder, Craig J. (Res.) 189  
Schemel, Lawrence J. (Res.) 59  
Schexnayder, Rebecca E. (Members-at-Large) 416  
Schroeder, Cygnet A. (Members-at-Large) 288  
Schulz, Eldon G. (Members-at-Large) 288  
Scroggin Jr., Carroll D. (Craighead/Poinsett) 102  
Sexton, Jon A. (Pulaski) 632  
Sheppard, Joseph E. (Pulaski) 188  
Shields, Eddie (Res.) 59  
Shuffield, James E. (Pulaski) 188  
Sifford, Mark D. (Craighead/Poinsett) 238  
Snyder, Victor F. (Members-at-Large) 345  
Soto-Figueroa, Sergio (Pope) 188  
St. Clair, Kevin L. (Members-at-Large) 288



Stank, Thomas M. (Members-at-Large) 577  
 Stern, Scott (Pulaski) 238  
 Steward Jr., Rodney D. (Members-at-Large) 458  
 Stewart, Tracy D. (Res.) 59  
 Strickland, Glen F. (Members-at-Large) 289  
 Subramanyam, Nanjunda S. (Members-at-Large) 345  
 Suprock, Mark D. (Craighead/Poinsett) 416

# -T-

Tait, Amy S. (Res.) 189  
 Tait, Layre S. (Sebastian) 148  
 Talbert, Michael L. (Pulaski) 148  
 Tan, Benjamin S. (Members-at-Large) 633  
 Tapley, Thomas S. (Pope) 576  
 Thomas, Paul C. (Garland) 59  
 Thomason, Steven D. (Res.) 59  
 Thomsen-Hall, Kathleen A. (Pulaski) 527  
 Thorn Jr., Garland M. (Res.) 527  
 Tielens, Don R. (Members-at-Large) 459  
 Torres, Stephen E. (Members-at-Large) 459  
 Towns II, Myron B. (Members-at-Large) 287  
 Travis, Patrick M. (Res.) 102  
 Tukivakala, Prabhakara R. (Phillips) 344  
 Turner, Sammy L. (Res.) 189  
 Tyler, Richard L. (Miller) 576

# -U-

Ulmer, Minna P. (Union) 344

# -V-

Verma, Virendar K. (Pulaski) 632

# -W-

Waack, Timothy C. (Sebastian) 189  
 Waner, Milton (Pulaski) 238  
 Warner Jr., Robert L. (Craighead/Poinsett) 59  
 Waters, Samuel G. (Res.) 102  
 Webb, Sherilyn M. (Res.) 59  
 Weiss, David W. (Pulaski) 148  
 White, Edward L. (Res.) 189  
 Whitely, Brent J. (Res.) 577  
 Whitney, Richard N. (Washington) 458  
 Willadsen, Diana S. (Res.) 102  
 Williamson III, Arian (Pulaski) 238  
 Wood, Mark C. (Members-at-Large) 345  
 Wood, Russell H. (Members-at-Large) 289  
 Woods, Jerrye A. (Res.) 102

# -Y-

Yates, Jeffrey K. (Res.) 189

## Advertisers Index

*Advertising Agencies in Italics*

American Physicians Insurance Exchange .... inside front  
 Arkansas Blue Cross & Blue Shield ..... 615  
 Arkansas Express Claims ..... 637  
 Calan - G.D. Searle & Company ..... inside back  
     *William Douglas McAdams, Inc.*  
 Central Arkansas Rehabilitation Hospital ..... back cover  
     *Walker & Associates*  
 ClaimNet, Inc. .... 604  
 Eli Lilly & Company ..... 596/597  
     *Garrison, Jasper, Rose & Company*  
 The Equity Resources Group ..... 622  
 Tommy Farrell Associates ..... 599/626  
     *Thomas J. Farrell Agency*  
 Freemyer Billing Services ..... 600  
 Herb Walters & Associates, Inc. .... 623  
 Medical Personnel Pool ..... 619  
 Medical Protective Company ..... 627  
     *Ferguson Advertising, Inc.*  
 MEDX ..... 606  
 Orthopaedic Research & Education Foundation ..... 614  
 Palisades Pharmaceuticals ..... 633  
     *Design and Advertising*  
 Parke Davis ..... insert  
     *Thomas G. Ferguson Associates, Inc.*  
 Postgraduate Medicine ..... 597  
 Radiology Consultants ..... 641  
 Rather, Beyer & Harper ..... 600  
 Riverside Motors, Inc. .... 605  
     *Benson/Smith Advertising*  
 State Volunteer Mutual Insurance Company ..... 594  
     *The Maryland Group*  
 Tanyard Springs ..... 593  
     *A. Tim Irby Advertising, Inc.*  
 USA Homes, Inc. .... 606  
 U.S. Army ..... 600  
     *Young & Rubicam Inc./Army Group*  
 U.S. Air Force ..... 645  
     *Bozell, Inc.*  
 U.S. Air Force Reserve ..... 606  
     *Hameroff/Milenthal/Spence, Inc.*



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For the many faces of mild hypertension

\*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

### BRIEF SUMMARY

**Contraindications:** Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

**Warnings:** Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

**Precautions:** Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

**Adverse Reactions:** Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:  
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### **Central Arkansas Rehabilitation Hospital**

2201 Wildwood Avenue • Sherwood, AR 72116 • (501) 834-1800



### **Northwest Arkansas Rehabilitation Hospital**

200 West Center • Fayetteville, AR 72702 • (501) 444-9367



### **Northeast Arkansas Rehabilitation Hospital**

1201 Fleming Avenue • Jonesboro, AR 72403 • (501) 932-0440







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